

THE LIABILITY OF PROVIDERS OF MENTAL HEALTH SERVICES IN NEGLIGENCE

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Recently the High Court considered the question of the liability of a mental health provider for the actions of someone whom they had briefly treated.¹ After a short period during which the service involuntarily detained the individual under relevant legislation, the service released the individual into the care of a friend. Later on that day, the person released killed his friend. The High Court allowed an appeal against a finding of the New South Wales Court of Appeal that the mental health service provider had owed, and had breached, legal obligations to the family of the person killed, denying compensation to the family on the basis the service provider did not owe a duty of care to the family. It will be argued the High Court was wrong to deny that a mental health service provider could owe, or did owe, a duty of care to victims of those to whom the service provider provided services.

INTRODUCTION

The common law has long struggled to provide a rational basis to explain the circumstances in which the actions or omissions of one person leading to injury or death to another are actionable. For a time the law was content to accept that certain categories of relationship gave rise to civil obligations recognised by the law,² apply strict rules forbidding recovery in other categories of case,³ but deny a generalised duty of care. This changed in 1932 with acceptance of a generalised duty of care principle based on the concept of reasonable

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¹ *Hunter and New England Local Health District v McKenna; Hunter and New England Local Health District v Simon* [2014] HCA 44 (*Hunter*).

² *Heaven v Pender* (1883) 11 QBD 503 (CA).

³ For example, the doctrine of common employment making it more difficult for employees to successfully sue their employers, and the defence of contributory negligence applied as a complete defence: *Butterfield v Forrester* (1809) 11 East 60; 103 ER 926; *Priestley v Fowler* (1837) 3 Mees and Wels 1; 150 ER 1030, non-liability of highway authorities with respect to non-feasance: *Parsons v St Mathew, Bethnal Green* (1867) LR 3 CP 56, 60 (Willes J), *Buckle v Bayswater Road Board* (1936) 57 CLR 259; denial that a property owner owes a duty of care to users of a nearby road, with respect to straying animals not known to be dangerous: *Searle v Wallbank* [1947] AC 341; *SGIC v Trigwell* (1979) 142 CLR 617, denial of a claim by one person based on the death of another: *Baker v Bolton* (1808) 1 Camp 493, 170 ER 1033; *Woolworths Ltd v Crotty* (1942) 66 CLR 603.

foreseeability and ‘neighbours’,⁴ together with statutory reform.⁵ The difficulty has been that at least in some circumstances, the *Donoghue* principle is seen to provide, or at least to raise fears of, ‘too much’ liability, or open-ended liability which might have undesirable social consequences.⁶ This objection has sometimes generally,⁷ and sometimes in relation to particular categories of case, led to the development of principles that make it harder in particular cases to successfully bring an action. Examples of the latter have involved claims of what lawyers call ‘nervous shock’,⁸ claims for purely financial loss,⁹ and claims against public authorities.¹⁰ The recent High Court decision involved both the first and third type of these ‘difficult’ cases. The Court has also noted that it is ‘exceptional’ to find one person liable for the actions or omissions of another.¹¹ That is also a feature of the current context. I turn now to explain the case and the decisions made with respect to it (Part A), before placing the decision in the broader context of precedent and principle (Part B). In Part C, I explain why I respectfully believe the High Court decision was incorrect.

⁴ *Donoghue v Stevenson* [1932] AC 562.

⁵ For example, legislation known colloquially as ‘Lord Campbell’s Act’ to overcome most of the impact of the decision in *Baker v Bolton* (1808) 1 Camp 493, 170 ER 1033; see generally Peter Handford ‘Lord Campbell and the *Fatal Accidents Act*’ (2013) 129 *Law Quarterly Review* 420; s24A *Wrongs Act 1958* (Vic)(abolition of doctrine of common employment); and the introduction of civil liability legislation in some jurisdictions following the insurance ‘crisis’ of the early 21st century: eg *Civil Liability Act 2002* (NSW).

⁶ In other words, ‘liability in an indeterminate amount, for an indeterminate time to an indeterminate class’: *Ultramares Corp v Touche* 174 NE 441, 444 (N.Y Court of Appeals 1932)(Cardozo J).

⁷ For example, the use of the notion of ‘proximity’ as a control mechanism (*Gala v Preston* (1991) 172 CLR 243, or the explicit consideration of policy reasons (if any) for the denial of a duty of care: *Anns v Merton LBC* [1978] AC 728; *Caparo Industries Plc v Dickman* [1990] 2 AC 605; subsequently proximity was rejected: *Hill v Van Erp* (1997) 188 CLR 159; more recently the use of concepts such as ‘control’ and ‘vulnerability’ have been adopted: *Perre v Apand Pty Ltd* (1999) 198 CLR 180.

⁸ Examples of ‘control mechanisms’ used here have included the concept of a person with normal fortitude, the concept of a ‘sudden shock’ and concepts of direct perception and immediate aftermath: *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310; subsequently these fell out of favour in the common law: *Tame v New South Wales* (2002) 211 CLR 317.

⁹ For instance, a requirement of an assumption of responsibility and (reasonable) reliance: *Hedley Byrne v Heller and Partners* [1964] AC 465.

¹⁰ For example, past distinctions between policy and operational decisions, use of so-called *Wednesbury* unreasonableness to determine the liability of a public authority: *Sutherland Shire Council v Heyman* (1985) 157 CLR 424; *Shovin v Wise* [1996] AC 923; the fact that non-feasance was not actionable (overturned in Australia in *Brodie v Singleton* (2001) 206 CLR 512; legislation abolishing past Crown immunity from suit includes the *Petition of Rights Act 1860* (UK) and *Crown Proceedings Act 1947* (UK), *Judiciary Act 1903* (Cth)(s64), and Australian state legislation.

¹¹ *Smith v Leurs* (1945) 70 CLR 256, 262-262 (Dixon J)(excepting vicarious liability); see also *Michael v Chief Constable South Wales Police* [2015] UKSC 2, [97](Lord Toulson, with whom Lord Neuberger, Lord Mance, Lord Reed and Lord Hodge agreed).

I SIGNIFICANT FACTS, DECISION OF COURT OF APPEAL AND HIGH COURT

The facts were tragic. Mr Pettigrove (P) had suffered mental illness for at least 20 years. He suffered from chronic paranoid schizophrenia and was being treated for this condition in regional Victoria. While in New South Wales with a friend Rose (R), he was taken by ambulance to the hospital, primarily because he was experiencing 'physical jerks'. Upon arrival at 4.30am, a doctor contacted Dr Coombes who advised the doctor to complete the documentation to allow P to be involuntarily detained in the hospital under that state's mental health legislation, and to give P an injection of an anti-psychotic drug and a sedative. In order that P be so detained, it was necessary to obtain appropriate authorisations. Dr Coombes, who observed P at the hospital signed to the effect that P was mentally ill within the meaning of the Act, as did the superintendent of the hospital at the time. The form was completed by a duty doctor Dr Saw, who noted that P was suffering suicidal ideation, and psychotic depression (with a question mark). His notes included a statement of 'concern harm to self/others'. Dr Saw indicated on the forms that the patient's detention was necessary for his own protection and that of others. A form that Dr Coombes signed confirmed that P had presented with 'depression (and was) psychotic', and that the principal diagnosis was 'exacerbation of chronic paranoid schizophrenia'.

Later that morning, an Assessment of Current Presentation form was completed by a clinical nurse. The assessment reiterated the 'physical jerks' symptoms and explained them as psychotic phenomena. It records the patient reporting hearing voices that bothered him, that he had a history of not taking his medication. Another form, apparently completed by an unidentified nurse, rated P 2 out of 7 on a 'overactive, aggressive, disruptive or agitated' scale and 3 out of 7 on a 'problems with hallucinations and delusions' scale. A similar form completed by another nurse the following day scored P 0 and 1 respectively on these criteria.

The legislation at the time required that any person involuntarily detained under mental health legislation had to be examined within 12 hours of admission by the medical superintendent at the hospital. The person could only be kept in detention if the superintendent certified that the person was mentally ill or mentally disordered. The superintendent, Dr Wu, stated that P was mentally ill, noting that she had observed 'bizarre behaviour, inappropriate eye movement plus verbal activity, suicidal ideation, unresponsive at times, and concern harm to self/others', with a conclusion of 'schizophrenia'. The Act required a further review to be conducted by a psychiatrist. Dr Coombes did this review, and he also concluded P was mentally ill. His notes recorded his awareness of P's long history of paranoid schizophrenia, having sighted P's

medical history from Victoria. (This medical history was extensive, including a history of non-compliance with medication, jumping in front of trucks, lying face down on roadways, talking to himself, likely auditory hallucinations). He noted the patient looked perplexed and bewildered. He noted the patient had not taken medication for at least 7 months. His notes concluded that the patient should be detained overnight, and then transferred to his mother's home in rural Victoria in the company of his friend Rose. Dr Coombes then arranged for P to be taken from the assessment area to the secured mental health unit; he arranged two 'solid males from emergency' to make this transfer.

On the day that P was involuntarily detained, Dr Coombes spoke with P, P's mother, and R. Dr Coombes apparently discussed various treatment options with P's mother and R. Dr Coombes noted that P's mother wanted him home in Victoria, and Rose was happy to drive him home. It was agreed that P would be detained in the New South Wales hospital overnight, and that R would then drive with P to his mother's home in regional Victoria, near where he had been receiving medical treatment to date. This would involve a car trip of approximately 1000 kilometres. Dr Coombes noted that his strong preference was for the pair to travel a route with a number of psychiatric services along it, so they could provide assistance along the way if needed.

Following that meeting, Dr Coombes completed another form. He ticked boxes indicating that there was no foreseeable risk of P inflicting harm on himself or others. On this form, he again referred to the patient's long-term schizophrenia condition, noting the patient was 'not obviously hallucinating'. He indicated there was no apparent risk to himself or to others, and that P was to be given no medication upon discharge. This was apparently because the two would be sharing the driving, and Dr Coombes did not want to make P drowsy. In the event, he was given one night's supply of medication. The evidence was that if P had been given a depo injection prior to commencement of the journey, it would have reduced the risk of 'something untoward' happening on the journey.

During the night in which P was detained in the New South Wales facility, he was observed by nursing staff. They noted that he remained awake at all times during that evening, and appeared to be speaking to himself loudly. When nursing staff approached the door to his room, he would become quiet.

On the next day, P was discharged into the care of his friend R. R arrived at the hospital a few hours later than what had been agreed on the previous day. This was relevant in terms of the journey from regional New South Wales to regional Victoria. As indicated, it was a journey of approximately 1200 kilometres. The fact that the two set off later than originally anticipated increased the risk of something going wrong during the journey. There was medical evidence to suggest that the risk of someone with paranoid schizophrenia suffering an 'attack' was higher at night than during the day.

During this journey, P said he started to believe that R had killed him in a previous life. He strangled and killed R in the vehicle. Subsequently P committed suicide. The legal claim was brought by members of R's family. His mother and sisters claimed they developed a psychiatric condition as a result of what happened to R, and they claimed the medical authority was liable to them in negligence. The trial judge found that the medical authority had not breached its duty of care to the family; the Court of Appeal found by majority (Macfarlan JA and Beazley P, Garling J dissenting) that the medical authority breached the duty of care it owed to the family; the High Court found the medical authority did not owe a duty of care to the family, dismissing their claim.

The medical evidence considered in the case was considerable, and in some ways conflicting. To summarise:

- Dr G concluded Dr Coombes had made a 'fundamental error of judgment' in deciding to release P one day after he had been involuntarily detained. Dr G stated it was most unwise to place P in the care of a friend when P's behaviour (including being awake all night, talking loudly to himself) suggested strongly he was experiencing auditory hallucinations. This made him a significant risk to himself and others. Dr G said this error was compounded by the failure to give P an injection prior to his release; it was not enough to provide him with medication for one night; his history suggested he would not take it. A longer time period was needed to properly assess P given that some psychosis sufferers could have brief periods of lucidity. There was little prospect of ongoing treatment if and when he got back to Victoria.
- Dr K essentially agreed with Dr G, emphasising P's record of failing to take medication, and past reckless and dangerous behaviour. Dr K found it was likely that on the day of admission to hospital P was likely 'acutely psychotic', such that a conclusion by Dr Coombes on the following day that P was 'no(t) an apparent risk to safety of self or others' was not a conclusion reasonably available on the evidence, and contradicted information on other forms completed regarding P's admission. Dr K noted that the time P had been involuntarily detained, it was noted that P was at risk of harm to self and/or others. Nothing occurred in the following 24 hours to change this assessment.
- Dr P noted the observations of the nurses on the night P spent in the hospital were critical. They suggested that P was psychotic. Even if it was appropriate to decide on the previous day to release him on the next day, the nurse's observations rendered it inappropriate. Dr P noted paranoid schizophrenia was associated with unpredictable

behaviour. It was not clear that Dr Coombes had sought or obtained the records of the nurses' observations of P overnight, prior to P's release the following morning.

- Dr C concluded Dr Coombes had made reasonable decisions. Dr C said that a diagnosis of psychosis was not a reason in itself to keep someone in hospital. The risk of someone with psychosis committing homicide was 'not much greater than for the so-called normal population'. P had no prior history of violence or harm to others. His scores of 0 and 1 on the test administered by the nurse on the second day were relevant. It might have prudent to delay discharge until the patient had settled for some days, but this was due to the risk P might harm himself, not that he would harm others, which Dr C found to be virtually impossible to predict.
- Dr T essentially agreed with Dr C. Dr T understood and supported the decision to lightly medicate P prior to the journey. Dr T said the risk of an assault on others was not reasonably foreseeable.
- Dr P also essentially agreed with Dr C, concluding Dr Coombes' decisions were not inappropriate. P had no prior violent history to others. Attempts to transfer him to Victoria were understandable given his family network was there. Long-term sufferers of paranoid schizophrenia typically became less dangerous over time. Dr P also noted statistics stating that about 52% of those with paranoid schizophrenia involuntarily detained under mental health legislation were discharged the following day.

All doctors agreed P was not fit to fly, even with an escort.

A Court of Appeal

By a majority of 2-1, the Court, in a very thorough judgment of 65 pages, found that the mother and sisters of Mr Rose were entitled to compensation based on a breach of the (common law) duty of care owed by the medical authority to them.¹² Macfarlan JA expressed the majority view, in terms with which Beazley P expressed agreement.

Macfarlan JA considered the elements of a negligence action. It is noteworthy that he did so in the context of whether the medical authority owed a duty of care to Rose, rather than whether they owed one to members of Rose's family. The assumption appears to have been made that if the hospital owed a duty of care to Rose, it would owe one to his family.¹³

¹² This was not a claim for breach of statutory duty.

¹³ [85]; Macfarlan JA said it was sufficient to consider whether the hospital owed a duty of care to Rose, since the hospital did not argue that the question of whether a duty of care was owed to (a) Rose and (b) his family might have different answers. The High Court cast doubt on the

Macfarlan JA was satisfied that such a duty of care existed, and noted that the trial judge had assumed that a relevant duty of care arose. The duty of care he accepted was a duty owed by the hospital to Rose to take reasonable care to prevent P causing physical harm to Rose.¹⁴ He referred to indicia of a duty of care obligation being owed by one to another, including the nature of control exercised by the defendant over the risk of harm, degree of vulnerability of those to whom the duty is said to be owed, and whether the existence of such a duty was consistent with the asserted duty of care.

In finding that a duty of care existed, Macfarlan referred to the decision of the New South Wales Court of Appeal in *Hunter Area Health Service v Presland*.¹⁵ Briefly, the case there against Hunter involved a psychiatric patient released from their care who killed his brother's fiancé within six hours of release. He was acquitted on the basis of mental illness, but confined under mental health legislation. He sued the medical authority for releasing them when he did for the mental anguish he suffered from the killing and consequences from it. By majority there, the court found the defendant did not owe the plaintiff a duty of care. Macfarlan JA here relied on the dissenting judgment in *Presland* of Spigelman CJ, who found that a duty of care existed in that case, based on control and vulnerability. Spigelman CJ there found no conflict between the asserted common law duty and relevant obligations of authorities under the state's mental health legislation. And the judges in the majority in *Presland* made it clear that their decision in that case did not preclude an action different in kind from the one at issue there. Santow JA specifically found that an action might be brought by a third party who had suffered serious physical harm due to actions of the person released.¹⁶

Macfarlan J decided that the medical authority had breached its duty of care. He was not satisfied that representatives of the authority could, on one day, be convinced that P warranted being involuntarily detained under the mental health legislation, and then apparently be satisfied on the very next day that the patient could be released without significant risk. It was noteworthy Dr Coombes had not scheduled another appointment prior to release. The patient's symptoms were likely to fluctuate, and observations over just a few hours were not satisfactory in the context of a psychotic patient. Admitting authorities had noted patient was at risk of harm to himself or others. The overnight nurses had observed the patient to be in an agitated state. Dr Coombes obviously had some concerns about the journey, but was apparently

correctness of this approach: *Hunter and New England Local Health District v McKenna*; *Hunter and New England Local Health District v Simon* [2014] HCA 44, [14](French CJ Hayne Bell Gageler and Keane JJ), in terms with which I agree.

¹⁴ [108].

¹⁵ [2005] NSWCA 33.

¹⁶ [367].

satisfied with the existence of mental health facilities along the intended path. It was common knowledge that the danger of a psychotic episode increased at night. Dr Coombes knew it was likely the two would be in the car together at night, given the length of journey involved. Dr Coombes declined to give P a depo injection which would have reduced the risk of an incident. He knew P had a history of not taking medication, and had not had depo for seven months prior to admission. Medication given to the plaintiff on the day of admission would likely have worn off by the time of the journey. Macfarlan JA concluded that at the time of discharge, there was a foreseeable and not insignificant risk of P causing harm to R. In terms of determining whether a reasonable person would have taken precautions, factors like the probability of harm occurring, likely seriousness of harm, burden of taking precautions and social utility of the activity that caused the harm were relevant.¹⁷ Here the risk of some harm to Rose was high; the risk of serious harm lower but still significant. Very serious harm could occur. The hospital had the capacity to detain P for longer and it would not have imposed an unreasonable burden upon them to do so. In terms of the social utility of the action (releasing P), whilst the legislation did require P to be treated with the measures least invasive of his human rights, including the right to movement, the Act was also clearly concerned with 'control' of mental health patients for the purposes of treatment, but also protection of the patient and others.

Macfarlan JA decided that the medical authority had caused the death of Rose. In terms of s5D of the *Civil Liability Act 2002* (NSW), their actions in releasing P were a 'necessary condition' of the occurrence of the harm in the sense that the opportunity for P to harm Rose only arose because of the hospital's decision to release P.¹⁸

In dissent, Garling J denied that a duty of care was owed. Although the parties apparently conceded that if the hospital owed a duty of care to Rose, it also owed one to his family, Garling J suggested this concession was not appropriate. He pointed out the law had always taken a narrower approach to claims for psychiatric injury, a position maintained by s30 of the *Civil Liability Act 2002* (NSW). However, his main ground of decision was that the hospital did not owe a duty of care to Rose. He reached this conclusion after reading the relevant provisions of the mental health legislation. Garling J stated that the Act was expressly focused on care, treatment and control of the mentally ill. It did not expressly refer to protection of the public, or include it as an objective to be pursued under the Act. It consistently reflected a sentiment that those suffering from mental health issues should be treated wherever possible in community-based settings in an informal and voluntary basis; involuntary detention and treatment was very much a last resort. Patients were to be

¹⁷ S5B *Civil Liability Act 2002* (NSW).

¹⁸ [184]-[187].

subject to the least restrictive environment allowing them to obtain appropriate care and treatment.

Garling J observed the common law's general antipathy towards suggestions that one person is legally required to prevent another person from causing injury, and the important distinction between not causing harm, and not preventing harm. He reflected on comments by Brennan J in *Sutherland Shire Council v Heyman*¹⁹ to the effect that 'if people were under a legal duty to prevent foreseeable harm to others, the burden imposed would be intolerable'. He found that recognition of an obligation to someone such as Rose would be in conflict with the obligations the hospital had to patients such as P; as such no duty of care was owed.²⁰ Garling JA also concluded that even if a duty of care was owed, it had not been breached, since the risk of what actually transpired was not something that was reasonably foreseeable. He further found applicable a provision of the *Civil Liability Act 2002* (NSW) which confined liability for the exercise of special statutory powers to irrationality, and the parties had agreed that the decision here did not meet that standard.²¹ He commented on the failure of the plaintiffs to carefully articulate the parameters of the duty of care said to be owed.

B High Court

In November 2014, all five members of the High Court hearing the case allowed an appeal against the decision of the New South Wales Court of Appeal.²²

The primary reason for this decision was the Court's finding that the hospital did not owe the plaintiffs a duty of care.²³ It noted the significant emphasis that the relevant mental health legislation placed on measures that were minimally invasive to a patient's rights, dignity and self-respect. Specifically, the power to involuntarily detain a mentally ill individual under the mental health legislation could only be exercised where the medical superintendent believed that no other care of a less restrictive kind was appropriate and reasonably available.²⁴

The High Court found that to impose a duty of care to persons such as the

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²⁰ [257].

²¹ [295].

²² *Hunter and New England Local Health District v McKenna; Hunter and New England Local Health District v Simon* [2014] HCA 44.

²³ This decision was in line with trends observed by Stewart and Stuhmeke of the low success rate of plaintiffs in negligence actions in the High Court in recent times, and the even lower success rate of plaintiffs seeking compensation against public authorities: Pam Stewart and Anita Stuhmeke 'High Court Negligence Cases 2000-2010' (2014) 36 *Sydney Law Review* 585.

²⁴ On recent trends in favour of deinstitutionalization in the mental health context, see Jonathan Bach 'Requiring Due Care in the Process of Patient Deinstitutionalisation: Toward a Common Law Approach to Mental Health Care Reform' (1989) 98 *Yale Law Journal* 1152.

plaintiffs here on the hospital in such cases would be in conflict with these provisions of the mental health legislation. The mental health legislation required focus to be on the patient; the common law duty would require the hospital to have regard to others with whom the patient may come into contact later. The Court noted that often, the risk of a mentally ill person acting irrationally would not be insignificant, and the consequences of these actions could be serious. In many such cases, as a result of consideration of these risks, a decision maker would be minded to involuntarily detain, or continue to detain, a person suffering from mental illness. This conflicted with the clear indications in the legislation that involuntarily detention was to be exercised as a last resort. This conflict was fatal to the existence of the posited common law duty of care.²⁵ Elsewhere, the High Court cast doubt on the correctness of the approach in lower courts which had treated as equivalent a putative claim by Rose himself, as opposed to a claim by his family.²⁶ It also hinted at indeterminacy issues, briefly raising concerns that if a duty of care was held to be owed to Rose and his relatives, it would be difficult to rule out claims by anyone with whom someone such as P might come into contact post-release.²⁷

II PRECEDENT ON THE QUESTION OF WHETHER A BODY WITH STATUTORY RESPONSIBILITIES OWES A DUTY OF CARE

As indicated earlier, in the past the Crown, and bodies entitled to the shield of the Crown, were considered to be immune from liability in tort. This, together with an immunity from statute, was of ancient vintage, with the classic reference being to a quote in 1615 that ‘the King cannot do a wrong’.²⁸ This

²⁵ [29]-[31]; the finding that no duty of care was owed meant the High Court did not consider the question whether the duty of care had been breached, what its precise scope might be, or whether the duty of care might be indeterminate. Nor was the Court required to consider the application of other sections of the *Civil Liability Act 2002* (NSW) in relation to claims for psychiatric injury and claims against public authorities.

²⁶ [15]. The High Court might have drawn support for this approach from the earlier decision of *Chester v Waverley* (1939) 62 CLR 1, a tragic case involving the drowning of a child in a trench dug by a Council. His mother claimed damages for a psychiatric illness she claimed she suffered after observing her child being found in and recovered from the trench. The Court denied the woman’s claim, but opined that if the son had lived but merely suffered injuries, he would have had a claim, as would any dependants of his, had he been older: 7 (Latham CJ), 11 (Rich J). It is submitted that the High Court was correct, with respect, on both occasions, to treat as separate and independent claims the claim (if any) of the immediate victim, and the claim of those who suffered psychiatric illness as a result of the injury to the immediate victim. (This is not intended to indicate that the author agrees with the outcome in *Chester*, which denied to the boy’s mother a claim in nervous shock on the basis that a person of normal constitution would not suffer such a psychiatric injury in such circumstances).

²⁷ [16].

²⁸ *Magdalen College Case* (1615) 11 Co Rep 66, 72a; 77 ER 1235, 1243 (Lord Coke); adopted by Griffith CJ in *Sydney Harbour Trust Commissioners v Ryan* (1911) 13 CLR 338, 365 (Barton J)

immunity from suit was limited then abolished in the United Kingdom in 1860 and 1947 respectively.²⁹ Its rejection is implicitly reflected in s64 of the *Judiciary Act 1964* (Cth), and is expressed in various state legislation.³⁰ Despite this abolition, judicial reluctance to find government bodies, particularly in this context government bodies with statutory responsibilities, liable in tort remains evident.³¹ Examples of special treatment in this context have included past immunity from liability for acts of non-feasance³² (abolished in Australia in 2001),³³ as well as recognition of a distinction between policy decisions (which enjoyed at common law³⁴ and continue to enjoy in statute greater protection

to like effect, 370). If it were a word, rather than a phrase, what Coke said might be described as a contronym, because the phrase used can be interpreted in opposite directions. Specifically, it might mean that no court could find that the monarch had done a wrong, because it was not possible; alternatively it might mean that monarchs, like the rest of the population, ought not (more accurate than 'cannot') do a wrong. The suggestion of Crown immunity from liability and statute gained a footing (*R v Cook* (1790) 3 T.R 519, 521), and a strong presumption against the Crown being bound by statute accepted and applied for many years: *Province of Bombay v Municipal Council for the City of Bombay and Another* [1947] AC 58; there remains such a presumption in Australia, though it was weakened substantially in *Bropho v Western Australia* (1990) 171 CLR 1; Crown immunity from suit was abolished by legislation: see *Petition of Rights Act 1860* (UK) and *Crown Proceedings Act 1947* (UK); s64 *Judiciary Act 1903* (Cth); William Holdsworth 'The History of Remedies Against the Crown' (1922) 38 *Law Quarterly Review* 141.

²⁹ *The Petition of Rights Act 1860* (UK) and *Crown Proceedings Act 1947* (UK); in 1866 the House of Lords conceded a public body could be liable in tort: *Mersey Docks Trustees v Gibbs* (1866) LR 1 HL 93; *Geddis v Proprietors of Bann Reservoir* (1878) 3 App. Cas. 430, 455-456: 'it is now thoroughly well established that no action will lie for doing that which the legislature has authorised, if it be done without negligence, although it does not occasion damage to anyone; but an action does lie for doing that which the legislature has authorised, if it be done negligently' (Lord Blackburn).

³⁰ *Claims Against the Government and Crown Suits Act 1912* (NSW) s4; *Crown Proceedings Act 1958* (Vic) s23; *Crown Proceedings Act 1980* (Qld) s8; *Crown Proceedings Act 1972* (SA) s10; *Crown Suits Act 1947* (WA) s5; *Supreme Court Civil Procedure Act 1932* (Tas) s64; Greg Taylor 'John Baker's Act: The South Australian Origins of Claims-Against-the-Government Legislation' (2004) 27 *University of New South Wales Law Journal* 736.

³¹ 'There may be special factors applicable to a statutory authority which negative a duty of care that a private individual would owe in apparently similar circumstances': *Crimmins v Stevedoring Industry Finance Committee* (1999) 200 CLR 1, 34 (McHugh J). Recently a majority of the United Kingdom Supreme Court denied that a body set up as a protective system with public resources should be held liable in negligence for the actions of a third party not under their control, although the body might contain defects, be at fault, or have failed to achieve its purpose/s: *Michael v Chief Constable of South Wales Police and Another* [2015] UKSC 2, [114-115] (Lord Toulson, with whom Lord Neuberger, Lord Mance, Lord Reed and Lord Hodge agreed).

³² *Gorringe v Calderdale Metropolitan Borough Council* [2004] UKHL 15; Lord Hoffmann [38]; Lord Scott [65]; Lord Rodger [80] and Lord Brown [102].

³³ *Brodie v Singleton Shire Council* (2001) 206 CLR 512.

³⁴ *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 438 (Gibbs CJ), 469 (Mason J), 500 (Deane J); *Pyrenees Shire Council v Day* (1995) 192 CLR 330, 358 (Toohey J); cf 393 (Gummow

from civil action),³⁵ and merely operational decisions, where the prospects of civil action are greater. It has involved suggestions³⁶ that the liability of a public authority in the field of tort law should be governed by public law principles often referred to in short-hand as ‘*Wednesbury* unreasonableness’, an approach which again, by design or otherwise, would tend to narrow the window of legal liability of public bodies, rather than the typical expression of legal responsibility in tort. The usual fear in the law of tort of ‘floodgates litigation’ appears particularly pressing in this context. The power that some public authorities is clearly very significant, creating the possibility of liability on a range of fronts; ‘fronts’ being interests that might clash.³⁷ Local authorities sometimes need to make important policy decisions that a court might be ill-equipped to second-guess, even if it were minded to do so and it was within judicial remit to do so.³⁸ Defence of such actions might drain the resources of the organisation from more positive activities, in the context of limited public funding.³⁹

The question of the extent to which a body given statutory responsibilities owes a duty of care with respect to their exercise or non-exercise, and to whom, is one that had been considered by some previous cases. It is instructive to note how that issue had been dealt with previously.

An earlier case similar in some ways to the issues raised in *Hunter* is *Sullivan v Moody*.⁴⁰ That case dealt with child welfare legislation which enabled

J); the existence of a ‘policy’ exception was rejected by Gaudron McHugh and Gummow JJ in *Brodie v Singleton Shire Council* (2001) 208 CLR 512, 560.

³⁵ See, for example, s42 *Civil Liability Act 2002* (NSW); s83 *Wrongs Act 1958* (Vic); s35 *Civil Liability Act 2003* (Qld); s5W *Civil Liability Act 2002* (WA); s38 *Civil Liability Act 2002* (Tas); s110 *Civil Law (Wrongs) Act 2002* (ACT).

³⁶ *Stovin v Wise* [1996] AC 923, 953: ‘the minimum preconditions for basing a duty of care upon the existence of a statutory power ... are, first, that it would in the circumstances have been irrational not to have exercised the power, so that there was in effect a public law duty to act, and secondly, that there are exceptional grounds for holding that the policy of the statute requires compensation to be paid to persons who suffer loss because the power was not exercised’ (Lord Hoffmann, with whom Lords Goff and Jauncey agreed); this has not been accepted in Australia: *Crimmins v Stevedore Industry Finance Committee* (1999) 200 CLR 1, 35 (McHugh J), although an exception appears in *Pyrenees Shire Council v Day* (1995) 192 CLR 330, 347 (Brennan CJ), and was eventually rejected by the House of Lords: *X (Minors) v Bedfordshire County Council* [1995] 2 AC 633, 736 (Lord Browne-Wilkinson, for the House). Nonetheless, aspects of this approach have been subsequently adopted in civil liability legislation; see for example s43 and s43A *Civil Liability Act 2002* (NSW).

³⁷ This has been recognised as being particularly acute in relation to police investigations: *Tame v New South Wales* (2002) 211 CLR 317, 335 (Gleeson CJ), 396 (Gummow and Kirby JJ), 418 (Hayne J); *Hertfordshire Police v Van Colle* [2008] UKHL 50.

³⁸ These factors are explored in the judgment of Lord Diplock in *Dorset Yacht Co v Home Office* [1970] AC 1033, 1067; see also .

³⁹ *Hertfordshire Police v Van Colle* [2008] UKHL 50, [89](Lord Phillips) and [133](Lord Brown).

⁴⁰ (2001) 207 CLR 562.

a government department to take certain actions in relation to child welfare. Their overriding concern in exercising their powers was said to be the interests of the child. The legislation included a power to investigate claims of abuse of children. The legislation stated that provided a child welfare worker acted in good faith and in accordance with the section, they should not bear any legal liability in respect of the investigation, and that any liability that would otherwise accrue, would lie against the Crown. At issue were various reports which suggested that some fathers investigated had abused their children, conclusions later shown to be false. Those falsely accused brought defamation action against the child welfare workers who compiled the reports, and the State. The High Court dismissed the claim, on the basis that no duty of care was owed by the defendants to the plaintiffs; such a duty would be inconsistent with the responsibilities of the State under the Act with respect to child welfare.

The Court noted that the fact a defendant owed a duty of care to a third party, or was subject to statutory obligations constraining the manner in which powers or discretions may be exercised, did not of itself rule out the possibility that it might owe a duty of care to a plaintiff. Individuals could be subject to a number of duties, provided they were not irreconcilable.⁴¹ The Court noted, for example, that a medical practitioners reporting on the condition of an individual might owe duties to more than one person. However, problems would arise when a suggested duty would give rise to inconsistent obligations; in that circumstance, the posited duty would be denied. The Court also noted that where public authorities were charged with conducting investigations or exercising powers in the public interest or in the interests of a specified class of persons, the law would not ordinarily subject them to a duty to have regard to the interests of another class where it would impose upon them conflicting claims or obligations.⁴² Here there would be a conflict between the functions carried out by the child welfare authority, including investigating and reporting on possible child abuse, and a duty of care to those accused of that very thing. One would favour, in the event, of doubt that the claim be aired so it could be tested; the other would favour non-disclosure.⁴³

Several cases have involved claims against local authorities. In *Graham Barclay Oysters Pty Ltd v Ryan*,⁴⁴ consumers who suffered ill-health after eating oysters contaminated by faecal matter alleged negligence against the local authority and state government with responsibilities over the waters from which the oysters were harvested. The Court dismissed the claim. In so doing,

⁴¹ See also *Crimmins v Stevedoring Industry Finance Committee* (1999) 200 CLR 1, 77 (Kirby J), 102-103 (Hayne J).

⁴² 582 (Gleeson CJ Gaudron McHugh Hayne and Callinan JJ); the Court also expressed concern with possible indeterminate liability (582) and noted that the plaintiffs might have remedies under the existing law of defamation (581).

⁴³ 582.

⁴⁴ (2002) 211 CLR 540.

several observations were made with significance for the current context. McHugh J acknowledged that the mere fact a public authority was given powers exercise of which could prevent harm to others did not mean that the authority owed a duty of care. However McHugh J then cited situations where such an authority would ordinarily owe a duty of care: (a) the authority has used its powers to intervene in a field of activity and increased the risk of harm to person; or (b) if it knows or ought to know that a member of the public relies on it to exercise a power to protect their interests.⁴⁵ McHugh J identified several matters to be considered in relation to whether a statutory authority owes a duty of care:

- would a reasonable public authority reasonably foresee that its act or omission, including a failure to exercise its statutory powers, might result in injury to the plaintiff or their interests?
- was the authority in a position of control and did it have power to control the situation that brought about the harm to the injured person?
- was the injured person or their interests vulnerable in the sense that the injured person could not reasonably be expected to adequately safeguard themselves from harm?
- did the public authority know, or ought it to have known, of an existing risk of harm to the plaintiff or a specified class of persons including the plaintiff?
- would imposition of the duty of care impose liability with respect to the defendant's exercise of core policy-making or quasi-legislative functions?⁴⁶

In the same case, Gummow and Hayne JJ noted that the question of whether a statutory authority owed a duty of care to a class of persons involved consideration of factors such as the degree and nature of control exercised by the authority over the risk of harm that eventuated, the degree of vulnerability of those depending on the proper exercise by the authority of the powers, and whether the suggested duty is consistent with the terms, scope and purpose of the relevant statute.⁴⁷ In denying that a duty existed here, Gummow and Hayne JJ took into account that the state was not aware of any particular contamination risk, and there had been no prior outbreaks.⁴⁸

The High Court also considered questions of liability of public authorities

⁴⁵ 576.

⁴⁶ 577.

⁴⁷ 597-598; to like effect Kirby J (617); Callinan J spoke of 'vulnerability, power, control, generality or particularity of the class, resources of and demands upon the authority' (664); Gleeson CJ stated that a general legislative power to protect the public did not ordinarily give rise to a duty of care to a particular individual or members of a particular class (562).

⁴⁸ 607.

in *Brodie v Singleton Shire Council*.⁴⁹ There Gaudron McHugh and Gummow JJ noted that the statutory powers given to public authorities may give it such a significant and special measure of control over safety and property issues as to impose a duty of care. The duty might entail seeking to minimise a danger to safety or warn of the danger, but control was a paramount issue.⁵⁰ The duty of care was owed to a class of persons, identified as users of roads within the local authority's control.⁵¹ The joint reasons noted that 'the formulation of the duty of care includes consideration of competing or conflicting responsibilities of the authority'.⁵² Note that the position was not that the existence of competing or conflicting responsibilities *negated* a duty of care; it was that such facts would help shape, and confine, the posited duty of care.

Earlier the liability of a local authority was considered in *Pyrenees Shire Council v Day*.⁵³ There Council had statutory power to conduct works to prevent fires, as well as power to direct others to conduct works to prevent fires. A fire broke out at a particular premises which were part of the Pyrenees local government area. A council building inspector discovered a defect in a fireplace at the premises, which remained unsafe. The inspector told the tenant not to use the fireplace until it was fixed. He wrote a letter to one of the owners stating the fireplace should not be used until it was replaced, repaired or removed. The Council did not take any further steps. Two years later, a tenant who was unaware of the previous problems lit the fireplace. A fire ensued, destroying the premises and damaging an adjoining shop. The shop owners successfully sued the Council in negligence.

The Court found there was no conflict between the Council's responsibilities under the Act, and a common law duty to those living in the immediate area of the relevant premises. At least one of the reasons why Council was given power with respect to fireplaces was to reduce the risk of harm to nearby residents.⁵⁴ The plaintiff was within a class of claimants within the contemplation of the legislation.⁵⁵ The risk of not complying with the inspector's directions was extreme.⁵⁶ Neighbours were vulnerable and relied on the Council to exercise its powers appropriately and protect them from harm.⁵⁷

In the earlier case of *Sutherland Shire Council v Heyman*,⁵⁸ members of the High Court again considered the extent to which a local government authority

⁴⁹ (2001) 206 CLR 512.

⁵⁰ 559.

⁵¹ 577.

⁵² 580-581.

⁵³ (1995) 192 CLR 330.

⁵⁴ 342 (Brennan CJ).

⁵⁵ 347 (Brennan CJ).

⁵⁶ 348 (Brennan CJ).

⁵⁷ 359 (Toohey J); 370 (McHugh J).

⁵⁸ (1985) 157 CLR 424.

might owe a duty of care to those affected by its decisions, actions, or omissions. Gibbs CJ said that ordinary principles of the law of negligence should apply to public authorities, and that they could be liable if they exercised a power negligently, to someone who relied on what the public authority did, and could show they suffered injury as a result.⁵⁹ Mason J agreed that a public authority could owe a duty of care to others, casting it in terms of that authority 'creating a danger';⁶⁰ in that context the authority could owe a duty of care for the safety of others. Alternatively it could be based on reliance.⁶¹

A Non-High Court Decisions

1 United Kingdom

A case with somewhat analogous facts to the *Hunter* decision is *Home Office v Dorset Yacht Co Ltd*.⁶² There young detainees in an institution for at-risk youth escaped from an island. The detainees had criminal records, and had escaped from institutions in the past. They were not properly restrained or supervised by relevant officers. There was a deliberate policy with these institutions of giving those detained as much freedom and responsibility as possible, with a view to developing trust and responsible decision making. In the course of their escape, they collided with a yacht owed by the plaintiff, and then boarded it, causing further damage to it. The owner of the yacht sued the administrator of the institution in negligence. Four of five members of the House of Lords dismissed an appeal against a finding that the Home Office owed a duty of care it had to the yacht owner.

Lord Reid said there was good authority to support an action against a public authority that had exercised a statutory duty negligently. He distinguished cases involving an exercise of discretion, but found that if the discretion was exercised carelessly or unreasonably, an action might still lie. He acknowledged that the Home Office had conflicting considerations with which to contend – the public interest in protecting neighbours and their property from escapees, as opposed to the public interest in promoting rehabilitation.⁶³ The Home Office had pursued a policy of maximising detainees' freedom with rehabilitation in mind. This was reflected in statutory rules.⁶⁴ Importantly, the

⁵⁹ 445; to like effect *Crimmins v Stevedoring Industry Finance Committee* (1999) 200 CLR 1, 29 (McHugh J regarded as a 'settled category' of liability involving the exercise of statutory powers where it was reasonably foreseeable that if not exercised with care, others could be injured.

⁶⁰ 460.

⁶¹ 461, 464.

⁶² [1970] AC 1004.

⁶³ 1031.

⁶⁴ *Borstal (No 2) Rules*, 1949, r25 referred to detainees being able 'to develop his individuality on right lines and with a proper sense of personal responsibility. Officers shall therefore, while

fact that these conflicting considerations existed did not lead Lord Reid to a finding that to impose a duty of care on the Home Office with respect to an owner of a yacht nearby would be inconsistent with the Home Office's duties to detainees. Similarly Lord Morris acknowledged that officers had duties of care to their employers. This did not obviate a duty of care to detainees; rather he held that the common law duty of care to detainees would be 'conditioned by' the other duties.⁶⁵ Lord Morris emphasised the control that the officers had over those detained, in establishing that a duty of care existed.⁶⁶ Lord Pearson took a similar view. After acknowledging the Home Office's deliberate policy of light supervision of and freedom for those detained in youth detention facilities, he continued:

It would affect only the content of standard and not the existence of the duty of care. It may be that when the method is being intensively employed there is not very much that the defendant's officers can do for the protection of the neighbours and their property. But it does not follow that they have no duty to do anything at all for this purpose. They should exercise such care for the protection of the neighbours and their property as is consistent with the due carrying out of the Borstal system of training.⁶⁷

Lord Diplock also referred to reconciliation of competing interests, in accepting the existence of a duty of care in the case.⁶⁸ This balance of competing interests is also a theme in the Court of Appeal decision in *W v Edgell*,⁶⁹ there Bingham LJ discussed the balance between the patient's legitimate desire to regain freedom, and the public's legitimate desire to be protected from violence. President Brown (as he then was) discussed exceptions to the general rule in favour of patient confidentiality, finding that

firmly maintaining discipline and order, seek to do so by influencing the inmates by their own example and leadership and by enlisting their willing co-operation'.

⁶⁵ 1036.

⁶⁶ 1039.

⁶⁷ 1056.

⁶⁸ 1068-1069: 'this ... is the way in which the courts should set about the task of reconciling the public interest in maintaining the freedom of the Home Office to decide upon the system of custody and control of Borstal trainees which is most likely to conduct to their reformation and the prevention of crime, and the public interest that Borstal officers should not be allowed to be completely disregarding of the interests both of the trainees in their charge and of persons likely to be injured by their carelessness without the law providing redress to those who in fact sustain injury'; it should be acknowledged that Lord Diplock said in dicta that a decision to deliberately release a detainee which led to injury to a plaintiff would not lead to liability on the part of the Home Office, unless the decision was a wholly unreasonable one (1068). I have elsewhere acknowledged that the House of Lords would later abandon the 'wholly unreasonable' test for establishing whether or not a public authority was liable in negligence: *X (Minors) v Bedfordshire County Council* [1995] 2 AC 633, 736 (Lord Browne-Wilkinson, for the House).

⁶⁹ [1989] EWCA Civ 13.

in that case an exception was justified in the interests of public safety.⁷⁰ A claim such as this is less likely to be successful when the victim is not identified or identifiable as a member of a specific class.⁷¹

More common have been claims against police authorities in relation to their work. These are somewhat analogous to the situation in *Hunter* since they involve questions about the exercise, or non-exercise, of statutory functions in the context of a victim complaining of injuries suffered as a result of how those functions were carried out. There is evident reluctance to find police authorities liable in negligence for failing to prevent crime being committed, resulting in death or serious injury to victims and/or their families, even in circumstances where the victim had brought the specific danger to the attention of police.⁷² In these cases, the courts have established a general rule that police do not owe a duty of care to victims of crime to prevent crime from occurring. This is subject to exceptions, including where there is control, or an assumption of responsibility. These cases are of marginal relevance to the current situation, because in those decisions involving police, such as *Hill v Chief Constable of West Yorkshire*,⁷³ *Michael v Chief Constable of South Wales Police and Anor*,⁷⁴ and *Hertfordshire Police v Van Colle*,⁷⁵ there was an absence of control by the defendant of the actions of the wrongdoer. The wrongdoers were not detained in custody, and then released, providing no direct parallels with *Hunter*, where the person committing the violence had been involuntarily detained, and then released.

Despite this, the cases are of *some* use here. Their reasoning is in some

⁷⁰ See also *Jones v Smith* [1999] 1 S.C.R. 455 (solicitor-client privilege waived with respect to a psychiatric report which suggested that a particular person was likely to kidnap, rape and murder prostitutes in future due to overriding public safety interest in waiver).

⁷¹ *Palmer v Tees Health Authority* [1999] EWCA 1533 (Stuart-Smith, Pill, Thorpe LJ)(person had come to attention of authority as someone suffering from personality disorder and psychopathic personality, had been detained for a period in the hospital but had been released, had some history of violence and had suffered sexual abuse as a child, raped and murdered four year old girl; mother's claim for psychiatric injury rejected as disclosing no cause of action, because the plaintiff was not a member of an identified or identifiable class).

⁷² See for instance *Michael and Ors v Chief Constable of South Wales Police and Another* [2015] UKSC 2, where a majority of the Supreme Court found police did not owe a duty of care to prevent violence against a woman who had called police to inform them her ex-boyfriend was returning to her house and had threatened to kill her. The person taking the call assessed it as a 'G1' call, requiring immediate police response. They passed the message onto another police district, without reporting the threat to kill. It was then assessed as a 'G2' call, requiring a response within 60 minutes. About 15 minutes after the first call, the ex-boyfriend killed the victim. A claim by the victim's parents and children against the police was rejected on the basis no duty of care was owed. The general rule that police did not owe a duty of care to prevent crime applied

⁷³ [1987] UKHL 12.

⁷⁴ [2015] UKHL 2.

⁷⁵ [2008] UKHL 50.

places similar to the reasoning that led the High Court to deny that a duty of care was owed in *Hunter*, in the focus on practical difficulties caused by imposition of a duty of care on the relevant decision maker (for instance, concern that it would encourage the decision maker to adopt a ‘detrimentally defensive frame of mind’),⁷⁶ would have financial implications for the government⁷⁷ both in defending such actions and in taking pro-active measures to minimise risk of liability, and concern that the courts are not equipped to effectively second-guess police decisions regarding lines of enquiry.⁷⁸ These arguments will be further considered below. The other point is that in the most recent case of *Michael v Chief Constable of South Wales Police*,⁷⁹ the two dissenting justices made statements supportive of the position I take here:

The time has come to recognise the legal duty of the police force to take action to protect a particular individual whose life or safety is, to the knowledge of the police, threatened by someone whose actions the police are able to restrain.⁸⁰

2 *United States*

The Supreme Court of California considered analogous questions in *Tarasoff et al v University of California*.⁸¹ There P apparently told a University psychologist of his plans to kill a victim who had spurned his advances when she returned from holidays. Police briefly detained P, but he was then released. No-one informed the victim, or their family, of the threat. Two months later, P killed the victim. Her family brought action in negligence against the employer of the psychologist and police for failure to protect and failure to warn. In a landmark decision the Supreme Court found that a claim against the psychologist should proceed.

The Court expressly found that the legal responsibilities of the psychologist were not confined to their immediate patient, and extended at least to those whom they knew were threatened by the patient.⁸² The Court considered and rejected claims that to impose a duty of care on the psychologist to others would be inconsistent with the duty of care, including a duty of confidentiality, that the psychologist owed to their patient, and that free and open communication was essential to the practice of psychology, something which recognition of a duty of care to third parties would inhibit. The Court

⁷⁶ *Hertfordshire Police v Van Colle* [2008] UKHL 50, [89](Lord Phillips), [132](Lord Brown).

⁷⁷ *Michael and Ors v Chief Constable of South Wales Police and Anor* [2015] UKSC 2, [122](Lord Toulson, with whom Lord Neuberger, Lord Mance, Lord Reed and Lord Hodge agreed).

⁷⁸ *Hill v Chief Constable of West Yorkshire* [1987] UKHL 12.

⁷⁹ [2015] UKHL 2.

⁸⁰ [175](Lord Kerr), with whom Lady Hale expressed agreement: [197].

⁸¹ 551 P. 2d 334 (1976).

⁸² 344.

responded that this interest had to be weighed against the public interest in safety from violence,⁸³ concluding that ‘the protective privilege ends where the public peril begins’.⁸⁴

In *Lipari v Sears, Roebuck and Co*,⁸⁵ the offender had been involuntarily detained in a mental hospital run by the Veterans Administration, a United States agency. He was released and placed on a voluntary treatment program, which he subsequently discontinued. A month later he shot and killed one person and seriously injured another. The Court found that the United States agency owed a duty of care to third parties in relation to the offender. The Nebraskan Court specifically rejected the argument apparently accepted by the High Court in *Hunter*:

A second policy argument raised by the United States involves the goal of placing mental patients in the least restrictive environment. The United States contends that imposing liability on a psychotherapist would conflict with this goal because therapists would attempt to protect themselves from liability by placing their patients in a restrictive environment. This argument misinterprets the nature of the duty imposed upon the therapist. The recognition of this duty does not make the psychotherapist liable for any harm caused by his patient, but rather makes him liable only when his negligent treatment of the patient caused the injury in question ... despite the defendant’s protests to the contrary, a psychotherapist is not subject to liability for placing his patient in a less restrictive environment, so long as he uses due care in assessing the risks of such a placement.⁸⁶

Other American courts have noted the potential for conflict between goals of rehabilitation and treatment on the one hand, and public safety on the other. Notably, this has not led to a denial that those in charge of mental health facilities, prison etc owe or may owe a duty of care to members of the general public, but might mean that a duty of care (in the sense of a duty to warn, rather than a duty to protect) is more likely to be recognised where the person released sets themselves apart from the typical person detained in terms of specific dangerousness.⁸⁷ Further, liability might be limited to members of an identifiable class, if such is possible, rather than to the general public. A family

⁸³ 346.

⁸⁴ 347.

⁸⁵ 497 F. Supp 185 (D. Nebraska, 1980).

⁸⁶ 188-193; adopted and applied in *Durflinger et al v Artiles et al* 727 F. 2d 888, 901-906 (1984) (United States Court of Appeal, Tenth Circuit).

⁸⁷ *Rollins v Peterson et al* 813 P. 2d 1156, 1161 (1991): ‘the sensible approach is to recognise a duty on the part of the custodian that does not discourage the operation of transitional programs, but requires the custodian to use special care when the one in custody sets (themselves) apart .. in terms of dangerousness to an identifiable person or persons’ (Supreme Court of Utah).

member of the person attacked has been recognised as an identifiable class.⁸⁸ Some courts have permitted claims although no class is readily identifiable that is narrower than the general public.⁸⁹

The Supreme Court of Ohio decision of *Estates of Morgan v Fairfield Family Counselling Center*⁹⁰ involved facts similar to that of *Hunter*. Morgan had been diagnosed with schizophrenia and psychosis. He was being treated with psychotherapy and counselling with the defendant over several months. He began not taking his medication, and his parents noticed his behaviour was deteriorating, including their son becoming increasingly verbally abusive, apparently talking to someone who was not there, and complaining of physical assaults and pain that were not real. He was assessed twice in terms of involuntary detention, and on both occasions it was determined he did not fit the criteria. About six weeks after the last assessment, he shot and killed both of his parents, and seriously injured his sister during a game of cards.

The Supreme Court was comfortable with recognising that the defendant owed a duty of care to the plaintiffs in such a case. The Court specifically noted that many cases had involved the striking of a balance between countervailing public interests, including that patients be placed in the least restrictive environment and that they not be involuntarily detained in an effort to avoid liability.⁹¹ The Court admitted to

some trepidation concerning the imposition of a duty because of the fear that therapists will attempt to protect themselves from liability by involuntarily hospitalizing non-convict mental patients. This fear, however, has no reliable statistical support.⁹² Instead the statistical evidence that is available indicates

⁸⁸ *Hedlund v The Superior Court of Orange County* 669 P. 2d 41 (1983)(son who suffered a psychiatric injury after patient being treated by psychologists shot his mother in presence of son).

⁸⁹ *Estate of Johnson v Village of Libertyville* 496 N.E. 2d 1219, 1223 (1986).

⁹⁰ 673 N.E. 2d 1311 (1997)

⁹¹ 1321.

⁹² The judges cited Daniel Givelbar, William Bowers and Carolyn Blitch 'Tarasoff: Myth and Reality: An Empirical Study of Private Law in Action [1984] *Wisconsin Law Review* 443, 486; a similar result is found in Appelbaum, P 'The New Preventive Detention: Psychiatry's Problematic Responsibility for the Control of Violence' (1988) 145 *American Journal of Psychiatry* 779; Patrick Fox MD concluded that the effects of a duty to warn on the psychotherapist-client relationship had been minimal: 'Commentary: So the Pendulum Swings – Making Sense of the Duty to Protect' (2010) 38(4) *Journal of the American Academy of Psychiatry and the Law* 474, 475; as did Douglas Mossman MD 'Critique of Pure Risk Assessment Or, Kant Meets Tarasoff' (2006) 75 *University of Cincinnati Law Review* 523, 526: 'psychotherapists accept the fact that, while they may regard themselves as the caregivers of individual patients, they sometimes must function as agents for social protection'; as did Renee Binder and Dale McNeil 'Application of the Tarasoff Ruling and its Effect on the Victim and the Therapeutic Relationship' (1996) 47 *Psychiatric Services* 1212. Toni Wise commented on the positive social effects of the Tarasoff decision: 'to the extent that Tarasoff has encouraged therapists to probe more fully into potential violence and to consult with colleagues when they

that *Tarasoff* has not discouraged therapists from treating dangerous patients, nor has it led to an increased use of involuntary commitment of patients perceived as dangerous.⁹³

This partly answers concerns raised in the police liability context in the United Kingdom regarding whether recognition of a duty of care would cause the decision maker to adopt a 'detrimentally defensive' frame of mind. The research cited in the passage above casts doubt as to the extent to which recognition of a duty of care by the mental health professional in cases such as *Hunter* would lead to the kind of change in behaviour feared by some justices.⁹⁴

Fears that the *Tarasoff* decision would lead to an unsustainable increase in successful claims against mental health professionals for breaching the duty have similarly not been supported by empirical evidence. A study of more than 100 claims against mental health professionals for failure to protect or failure to warn at appellate level concluded that defendants are now rarely held to be negligent on grounds of failing to warn or protect. In reviewing 21 years of legal history, we found just four cases in which psychotherapists were found liable for breach of a *Tarasoff* duty.⁹⁵

Fears that recognition of a duty of care to third parties was inconsistent with the mental health professional's duty of care to the patient were also negated by comments such as the following from a practising psychiatrist and scholar that 'I can scarcely conceive of a psychiatric interview in which the patient's risk to self or others is not addressed'.⁹⁶ An empirical study among mental health professionals found that 'a duty to protect potential victims is not viewed as ethically repugnant'.⁹⁷

confront it, the decision may be a boon to the proper identification of the dangerous patient': 'Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of *Tarasoff*' (1978) 31 *Stanford Law Review* 165, 186.

⁹³ 1325.

⁹⁴ Kathryn Peterson concluded that concerns about defensive decision making in the current context 'show a concerning scepticism about the integrity of medical decision-making': 'Where is the Line to be Drawn? Medical Negligence and Insanity in *Hunter Area Health Service v Presland*' (2006) 28 *Sydney Law Review* 181, 187.

⁹⁵ Matthew Soulier, Andrea Maislen and James Beck 'Status of the Psychiatric Duty to Protect, Circa 2006' (2010) 38(4) *Journal of the American Academy of Psychiatry and the Law* 457, 469.

⁹⁶ Patrick Fox 'Commentary: So the Pendulum Swings – Making Sense of the Duty to Protect' (2010) 38(4) *Journal of the American Academy of Psychiatry and the Law* 474, 475.

⁹⁷ Daniel Givelbar, William Bowers and Carolyn Blitch '*Tarasoff*: Myth and Reality: An Empirical Study of Private Law in Action [1984] *Wisconsin Law Review* 443, 486, and 'our respondents only endorsed the broader principle that a therapist has ethical responsibilities to protect potential victims ... the data certainly contradict the assertion that therapists must only concern themselves with the welfare of their patients and not with that of society at large' (476); recently Thomas Halfemeister, Leah McLaughlin and Jessica Smith stated it was now widely acknowledged that the effect of the *Tarasoff* ruling had not been 'ruinous' to clinical practice:

While the general words of the *Restatement (Second) of Torts*⁹⁸ had been interpreted consistently with the Tarasoff decision to impose a duty on the mental health professional, the *Restatement (3rd) of Torts* is even more explicit; s41(b)(4) recognises specifically a duty of a mental health professional to third parties who might be harmed by the actions of their patient.⁹⁹

In summary, the American decisions demonstrate that it is not inconsistent with obligations owed by mental health professionals to recognise that they might owe a duty of care to those placed at risk by a decision to release a person from care. It has not caused major disruption to how mental health professionals do their work. It was not, and is not, inconsistent with their practice, and does not raise serious ethical issues. And the ‘sky has not fallen in’, in terms of unmanageable numbers of claims, or successful claims, against mental health professionals in this context.

III WHY THE HIGH COURT WAS WRONG TO DENY THAT A DUTY OF CARE EXISTED IN THE CIRCUMSTANCES

In my respectful opinion, the High Court was wrong to deny that a mental health authority could, or did, owe a duty of care to family members of a person killed by someone whom the mental health authority had just released. This denial was largely due to the Court’s finding of an inconsistency or incompatibility between the duty said to arise, and other provisions of the mental health legislation at the relevant time, most particularly the clear policy setting that involuntary detention was considered to be a last resort, and that treatment should be the least invasive of the patient’s dignity, human rights etc. I will now explain why I disagree with the High Court’s view. For reasons of space, I will not consider in detail issues that are relevant to the resolution of the dispute between the parties, but which were not part of the High Court’s decision in the case.¹⁰⁰ My focus is on the decision the High Court reached, and the reasons why in my respectful opinion it was incorrect.

‘Parity at a Price: The Emerging Professional Liability of Mental Health Providers’ (2013) 50 *San Diego Law Review* 29, 79.

⁹⁸ American Law Institute *Restatement (2nd) of Torts*.

⁹⁹ American Law Institute *Restatement (3rd) of Torts: Liability for Physical and Emotional Harm* (2011). It should be acknowledged that some states have moved to regulate by statute the liability of mental health professionals; see for discussion Michael Geske ‘Statutes Limiting Mental Health Professionals’ Liability for the Violent Acts of Their Patients’ (1999) 64 *Indiana Law Journal* 391.

¹⁰⁰ These include, for example, the fact that it was a claim for psychiatric injury, the question whether any posited duty of care was breached, and the question of causation.

A *The Act*

The authorities above clearly indicate that one important factor in deciding whether a statutory authority owes a common law duty of care to others with respect to the exercise of its powers is consideration of the object, scope and terms of the relevant statute.¹⁰¹

It is true, as the High Court pointed out in *Hunter*, that sections of the *Mental Health Act 1990* (now repealed) clearly indicate its focus on the treatment of individuals suffering from mental illness, and demonstrates appropriate sensitivity to the impact that involuntary detention and treatment may have on individuals by requiring least invasive means of treatment be used. For example, section 4 of the Act, setting out the objectives of the Act, and s20 made clear the exceptional and last-resort nature of the power to detain involuntarily, as to ss28, 29 and 35. All of these sections were appropriately discussed by the High Court in the course of making that point about the legislation.

However, other sections of the Act were not discussed by the High Court. Section 21 allowed a medical practitioner or authorised person to detain a person on the basis of an opinion that they are suffering from mental illness or a mental disorder. Chapter 3 of the legislation was entitled ‘Mentally Ill and Mentally Disordered Persons’. Section 8, in that chapter, stated that for the purposes of assessing whether a person should be involuntarily detained under the Act, a person is mentally ill or mentally disordered only if they meet the criteria set out in that part of the Act. That brings us to ss9 and 10. Section 9 stated that a person is a mentally ill person if they are suffering from a mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment and control of the person is necessary:

- (i) For the person’s own protection from serious harm; or
- (ii) *For the protection of others from harm* (emphasis added).

Section 10 stated that a person is a mentally disordered person if the person’s behaviour at a given time is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

- (i) For the person’s own protection from serious harm; or
- (ii) *For the protection of others from harm* (emphasis added).¹⁰²

¹⁰¹ For example, *Graham Barclay Oysters Pty Ltd v Ryan* (2002) 211 CLR 540, 563 (Gleeson CJ), 574 (McHugh J), 597-598 (Gummow and Hayne JJ)(with whom Gaudron J agreed (570)), 617 (Kirby J), 658-659 (Callinan J).

¹⁰² Sections 14 and 15 of the (current) *Mental Health Act 2007* (NSW) are in materially similar form, again including ‘protection of others from harm’ as one of the two criteria to be considered. This mirrors mental health legislation elsewhere: see *Mental Health Act 2014* (Vic) s29(b)(ii); *Mental Health Act 2000* (Qld) s13(1)(d)(i); *Mental Health Act 2009* (SA) s21(1)(b);

To emphasise, of the two criteria that a medical practitioner is to consider in assessing whether a person is suffering from a mental illness or mental disorder (concepts relevant to whether a person is to be involuntarily detained), one of them requires the decision maker to have regard to whether care, treatment and control of the person is necessary to protect others from harm.

Given this fact, it is very difficult to fathom, or accept, a (terse¹⁰³) finding of the High Court in *Hunter* that acceptance of a duty of care by the decision maker in such cases to possible victims of a person they might release would be inconsistent with the mental health legislation under which the decision to detain or release is made.¹⁰⁴ How can it be inconsistent, with respect, when the very Act itself expressly contemplates that the decision maker will, indeed requires that they do, take into account the risk to others in assessing whether a person is mentally ill or mentally disordered, concepts directly linked to questions of involuntary detention?¹⁰⁵

It is also worth recalling *Hunter Area Health Service v Presland*,¹⁰⁶ coincidentally a very similar case of negligence brought against a mental health service in that region. There the plaintiff had been taken by police to a hospital following what was termed ‘bizarre and violent’ behaviour involving telling a person ‘he didn’t think he could kill him’, hitting a victim with a fence paling, grabbing others (including a three year old child) by the throat, jumping up into the air, and claiming that the ‘rats must die’. He was then transferred to a public psychiatric hospital for assessment. That hospital released him on the same day, in the company of his brother. Six hours later the plaintiff killed his brother’s fiancé. He was acquitted of a charge of murder on the basis of mental illness, and was then committed in a psychiatric institution. When he was

Mental Health Act 2006 (WA) s26(1)(b)(i); *Mental Health Act 2013* (Tas) s17(1)(c); *Mental Health (Treatment and Care) Act 1994* (ACT) s26(p)(ii); *Mental Health and Related Services Act 1998* (NT) s14(A).

¹⁰³ The Court explained its findings regarding inconsistent duties in five paragraphs: [29]-[33].

¹⁰⁴ In this sense, the case is more akin to the finding in *Pyrenees* that although the Council owed obligations to a range of individuals, the obligation to a particular home owner complemented, and was not mutually exclusive of, obligations to owners of neighbouring properties, because the overriding obligation was public safety. The same can be said in this case; in that way *Sullivan v Moody* can be distinguished because there really could be a conflict in that instance between a duty to thoroughly investigate claims of child abuse, guided by the best interests of the child, and the right of a person under investigation to their reputation.

¹⁰⁵ To reiterate, the purpose of determining whether a person is suffering from a mental illness or mental disorder is to consider their involuntary detention, continued involuntary detention or community treatment order: s8.

¹⁰⁶ [2005] NSWCA 33; see for discussion Ian Freckelton ‘Liability of Psychiatrists for Failure to Certify: *Presland v Hunter Area Health Service and Dr Nazarian*’ [2003] NSWSC 754’ (2003) 10 *Psychiatry, Psychology and Law* 397; Kathryn Peterson ‘Where is the Line to be Drawn? Medical Negligence and Insanity in *Hunter Area Health Service v Presland*’ (2006) 28 *Sydney Law Review* 181.

released, he sued the mental health authority, arguing they were negligent in releasing him so soon on the first occasion, and if they had not done so, he would not have killed the victim and then been subsequently involuntarily detained, things which he claimed caused him emotional distress.

It is conceded that a majority of the New South Wales Court of Appeal rejected the plaintiff's claim in negligence. Notwithstanding this, comments made by that court are considered highly relevant to the current issue.

Spigelman CJ, who dissented in the result and would have allowed the claim, noted, as I have, the existence of ss9 and 10, including the reference to protection of others from harm as an important criterion to be considered in considering detention. He then noted that

If this were proceedings by a third party who had suffered harm at the hands of a mentally ill or disordered person, *then it would fall within the intended sphere of protection to which the statutory provisions expressly relate.*¹⁰⁷ (emphasis added)

Clearly these are dicta comments, but they fit precisely the situation at issue here. If Spigelman CJ were considering *Hunter*, he surely would have found the existence of a duty of care owed to the plaintiffs, based on these comments.¹⁰⁸ His conclusion (on the same provisions as those considered in *Hunter*) is diametrically opposed to the interpretation rendered by the High Court in *Hunter*. With respect, the view of Spigelman CJ is much preferred, based on the clear wording of ss9 and 10, sections to which the High Court did not refer in *Hunter*.

And while Spigelman CJ was dissenting in that case, one of the members of the majority, Santow JA, made it clear that while he rejected the suggestion that this plaintiff had a claim, he may have reached a different conclusion had the plaintiff been someone who suffered at the hand of a person negligently released from the care of a mental health unit.¹⁰⁹ This was in the context of his general statement that any person or organisation claiming an immunity from

¹⁰⁷ [29]; a leading scholar in the medico-legal field agrees: 'properly construed ... the criteria for involuntariness are not in conflict with the recognition of a duty to treat provided the criteria are satisfied': Ian Freckelton 'Legal Liability for Psychiatrists' Decisions About Involuntary Inpatient Status for Mental Health Patients' (2014) 22 *Journal of Law and Medicine* 280, 288.

¹⁰⁸ Spigelman CJ dismissed an argument that a finding that a duty of care was owed to those other than the patient would lead to the practice of defensive medicine: 'The Court ought to be slow to conclude that a medical practitioner acting true to his or her profession, would permit the process of formulating a professional opinion be distorted by the prospect of civil liability': [37]; in contrast Sheller JA was concerned that this might occur: [297].

¹⁰⁹ 'This is not the case of an action brought by a third party against a careless hospital who was physically injured during a psychotic episode at the hands of someone whose compulsory detention for treatment would have averted the injury to that person': [345]. Certainly, the fact that in *Presland* it was the wrongdoer who was the one claiming compensation was relevant to the court's decision to reject the claim.

general principles of negligence liability, including statutory authorities, had to satisfy a 'heavy burden of justification',¹¹⁰ and his general agreement with Spigelman CJ's espousal of relevant principles in terms of liability in negligence of statutory authorities.¹¹¹

Another state case found that a parole authority owed a duty of care to victims of someone they had released early upon conditions, based on specific suggestions that the person released was in breach of his parole conditions, placing children at risk. The court did not conclude there that a duty of care to these victims was inconsistent with the parole board's duties with respect to rehabilitation of offenders etc through the prudent use of early parole.¹¹²

Similarly, the United Kingdom decision of *Home Office v Dorset Yacht*, and American decisions such as *Tarasoff*, cause us to question the extent to which duties of care to those detained involuntarily do irreconcilably conflict with duties to those who might be injured by someone being released from care. In *Home Office*, the Court clearly concluded that recognition that authorities owed a duty of care to those who might be affected by escaped residents did not conflict with the policy behind the facility, which was to provide maximum freedom to residents and allow them to make decisions as much as possible. And the American decisions, led by *Tarasoff*, tend to negate the suggestion of an impossible conflict between the duty owed by mental health professionals to their patients, including minimally invasive treatment, and duties of care owed to those who might be injured by the person released from involuntary detention. In fact, such duties have happily co-existed in the United States for some years. The evidence is that it has not proven to be impossible, has not really changed the way in which mental health practice worked anyway, and was not inconsistent with ethical obligations owed by such professionals. Rates of litigation or liability against mental health professionals have not proven manageable. As always, there is no substitute for evidence-based decision making in preference to generalisations or assumptions.

B *Criteria for Recognition of a Duty of Care Owed by Public Authorities*

McHugh J (other justices are also cited below) cited¹¹³ five factors to be considered in deciding whether a public authority owed a duty of care:

- whether a reasonable public authority would reasonably foresee that its act or omission, including failure to exercise powers, might result in injury to the plaintiff

¹¹⁰ [345].

¹¹¹ [325].

¹¹² *Swan v State of South Australia* [1994] SASC 5114 (Bollen J, with whom Mohr and Duggan JJ agreed).

¹¹³ *Crimmins v Stevedoring Industry Finance Committee* (1999) 200 CLR 1, 39; *Graham Barclay Oysters Pty Ltd v Ryan* (2002) 211 CLR 540, 577.

- whether the public authority was in a position of control¹¹⁴
- whether the plaintiff/s were vulnerable in that they could not reasonably be expected to adequately protect themselves from harm¹¹⁵
- did the public authority know, or ought to have known, of an existing risk of harm to the plaintiff or of a class of persons of whom the plaintiff was one¹¹⁶
- whether the imposition of the duty would impose liability with respect to the defendant's core policy making or quasi-legislative functions.

I will apply each of these factors to the facts in *Hunter*.¹¹⁷

Regarding the first factor, it is clearly foreseeable that a person with a 20 year history of mental illness, psychosis, suffering from hallucinations, and on little medication might pose a danger to those around him. The hospital authorities were aware that P was to be released into the care of his friend Rose, and were aware that the two would be sharing a vehicle during a journey of 1200 kilometres. The fact that doctors were conscious that this was risky is

¹¹⁴ Control was also cited as a critical consideration in the context of whether a statutory authority owed a duty of care by Gummow and Hayne JJ in *Graham Barclay Oysters Pty Ltd v Ryan* (2002) 211 CLR 540, 597 (with whom Gaudron J agreed (570)); Kirby J (630), Callinan J (664); and in *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 254 (Gummow Hayne and Heydon JJ), 261 (Crennan and Kiefel JJ)(in the context of police officers with statutory powers); control is important to duty of care issues more generally: *Hill v Van Erp* (1997) 188 CLR 159, 198 (Gaudron J), 212 (McHugh J), 234 (Gummow J); *Perre v Apand Pty Ltd* (1999) 198 CLR 180, 195 (Gleeson CJ), 201 (Gaudron J), 326 (Callinan J); *Adeel's Palace Pty Ltd v Moubarak* (2009) 239 CLR 420, 436-437 (French CJ Gummow Hayne Heydon and Crennan JJ). As indicated above, the question of control or lack of it is also critical in decisions of the United Kingdom Supreme Court regarding whether a public authority owes a duty of care: *Michael and Others v Chief Constable of South Wales Police and Anor* [2015] UKHL 2, [99](Lord Toulson, with whom Lord Neuberger, Lord Mance, Lord Reed and Lord Hodge agreed).

¹¹⁵ Vulnerability was also cited as a critical consideration in the context of whether a statutory authority owed a duty of care by Gummow and Hayne JJ in *Graham Barclay Oysters Pty Ltd v Ryan* (2002) 211 CLR 540, 597 (with whom Gaudron J agreed (570)); Callinan J (664); *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 254 (Gummow Hayne and Heydon JJ) and 260 Crennan and Kiefel JJ in the context of police officers with statutory powers; vulnerability is important to duty of care issues more generally: *Hill v Van Erp* (1997) 188 CLR 159, 186 (Dawson J)(with whom Toohey J agreed (188)); *Perre v Apand Pty Ltd* (1999) 198 CLR 180, 195 (Gleeson CJ), 201 (Gaudron J), 220, 225 (McHugh J), 259 (Gummow J); Jane Stapleton 'The Golden Rule at the Heart of Tort Law: Protection of the Vulnerable' (2003) 24 *Australian Bar Review* 135.

¹¹⁶ This is relevant in terms of floodgates arguments. For example, the United States courts have been more likely to recognise a claim where the plaintiffs were specifically known to the defendants as being individuals likely to be affected by the actions of the person released (for example, family members and loved ones), rather than strangers (see discussion at footnotes 88 and 89).

¹¹⁷ The High Court did not consider these five issues in *Hunter* in determining whether a duty of care was owed; Macfarlan JA (with whom Beazley P agreed) considered and applied these factors in the New South Wales Court of Appeal: *McKenna v Hunter and New England Local Health District* [2014] NSWCA 476, [93]-[95].

borne out by the fact that they made enquiries about the route that would be taken, and were satisfied that there were numerous mental health facilities along the way. (It remains unclear how this would be of assistance if the patient suffered an episode in a place and at a time where it was not possible to obtain the required assistance, something which would tragically come to pass). And surely, it was foreseeable that if the patient did commit violence towards Rose, members of Rose's family would or might suffer psychiatric injury as a result.

Secondly, the public authority had very significant control over P.¹¹⁸ It had involuntarily detained him as the legislation empowered it to do, and had the power to continue to do so. The power to detain someone against their will is one of the most significant powers that a person or organisation can possess in relation to another.

Thirdly, the plaintiffs were vulnerable. They had no control over the release of P. They had no means of knowing what condition P was suffering from, and what it might lead him to do. They did not know what medication he was on. There is no evidence they were aware of his long-term mental health history, or his previous suicide attempts. They had no say in whether P was released or not, nor whether he should be released into the care of a friend to share a long journey. There was no way they could protect themselves from the injuries they suffered. To the extent that they might have implored Rose not to take the journey, they were not in a position to determine the danger that their son/brother was in by volunteering to share this journey as a friendly gesture. They did not have the professional expertise to make this assessment.¹¹⁹

¹¹⁸ This helps to distinguish the case of *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, where the High Court dismissed a claim that police had breached a duty of care they owed to herself and her husband. Police had observed her husband in a stationary vehicle with a hose pipe running from the exhaust to the interior of the vehicle, but had declined to exercise their power to detain persons who they believed were suffering from mental illness. One of the reasons the Court gave in denying a duty of care existed was the lack of control - that police did not control the source of the risk to the man, and they did not put the man in harm's way (255) (Gummow Hayne and Heydon JJ) (see also *Crennan and Kiefel JJ*, 261-263). The former joint reasons contrasted this with the position if the man were in police custody where control would be established (255). In contrast here, the defendant did control the source of the risk - they had involuntarily detained P and decided to release him. By so doing, they put those who might come into contact with P in harm's way.

¹¹⁹ Nor, indeed, did Rose, although the claim of Rose's family members is considered independent of any claim that Rose might have had. Some argue that had Rose survived, the defendant might have been able to successfully use the defence of *volenti non fit injuria*. However, as this requires a full appreciation of the risks taken on, it is unlikely that Rose did fully appreciate the risk, given that he was not an expert in mental health, was not aware of what medication P was or was not on, etc. It is likely he simply relied on the expertise of the defendant in determining, having regard to the risk that the person posed to themselves and to others, that the patient was not suffering a mental illness or mental disorder such as would or might lead to involuntary detention.

Fourthly, the defendant ought to have appreciated that to release P when they did posed risks to people like the plaintiffs. They knew he had a 20 year mental illness. They knew he was suffering from psychosis and auditory hallucinations. They knew he often did not take his medication, and was very lightly medicated at the time he was released. They knew he was to embark on a journey of 1200 kilometres in a car, and they knew that being out at night, and being in a confined space, both of which would occur during the journey, would increase the risk of a relapse. If they knew this presented real risks to the person P would share the car with, Rose, they must have known that if Rose suffered serious injury or death, that could well cause psychiatric injury to members of Rose's family. Case law has, eventually,¹²⁰ recognised that death or injury to a person may well lead to psychiatric injury to others who were close to the person, including family members.¹²¹

The High Court has repeatedly shown concern with the spectre of indeterminate liability. Would recognition of a duty of care in this situation create indeterminate liability? The answer is suggested to be 'no'.¹²² The plaintiffs are family members of a victim with whom P was placed, with the knowledge of the public authority. The victim collected P from hospital. One of the doctors had spoken with the victim directly about the travel arrangements. The plaintiffs are family members of the victim. In my view, recognition of a duty of care in those circumstances does not create the spectre of indeterminate liability to an unascertainable class. The class includes the person to whom the mental patient was released, and the family members of that person. It is not necessary, or necessarily helpful, for me to speculate further as to whether others are within the class of those who might be able to sue in such a situation.¹²³ For instance, what if the victims were strangers, who happened to be in the vicinity where P killed Rose? What if the victim was not Rose, but a service station attendant on the way etc. We could endlessly play the 'what if' game.

However, if recent experience with the law of tort has taught us anything, it

¹²⁰ The days of *Chester v Waverley Corp* (1939) 62 CLR 1, where three of the four High Court judges presiding could say it was not a 'normal' or expected (foreseeable) reaction that a mother would suffer psychiatric injury after seeing her drowned son retrieved from a trench (Latham CJ (10), Rich J (11), Starke J (13), are thankfully long gone.

¹²¹ *Jaensch v Coffey* (1984) 155 CLR 549; *Tame v New South Wales* (2002) 211 CLR 317.

¹²² This was the same answer given by Macfarlan JA in the New South Wales Court of Appeal (with whom Beazley P agreed): 'this concern (of indeterminate liability) is not in my view applicable to the present case as the plaintiffs' claim arises out of harm being suffered by a specific individual, Mr Rose, with whom the hospital had direct dealings and into whose custody the hospital released (P)': [97].

¹²³ It should be recalled, however, that the High Court has been prepared to frame the 'class' to whom the duty of care is owed very broadly. An instance was *Brodie v Singleton Shire Council* (2001) 206 CLR 512, where the duty was framed as being owed by the public authority to users of their roads.

is that it can be dangerous to try to answer every question in one case, with a comprehensive statement of all the occasions in which liability will be owed for this or that wrong, or definitive expositions of which principles cover all cases. We have realised that this is too ambitious a task, at least in this area, favouring now an incremental, case by case approach more familiar with general common law development.¹²⁴ So to say that members of Rose's family are owed a duty of care by the mental health authority in this case is not to comprehensively identify all possible members of the class that might be entitled to sue for a negligent release from mental health care. But it is not considered to raise the spectre of unmanageable, indeterminate liability. The United States evidence is instructive here, with empirical evidence that the prospects of successfully suing for negligent failure to protect, or failure to warn, remain low, even in a country often caricatured as being excessively litigious and the home of law suits that defy common sense, yet succeed.

And fifthly, to find a duty of care here would not intrude on the authority's core policy making or quasi-legislative functions. This duty of care relates to an operational decision about a particular patient. In terms of the past distinction between policy and operational decisions, it is clearly at the operational end, dealing as it does with the treatment of a particular patient. I have explained how recognition of a duty of care works with, and is not at cross-purposes with, policy in this area identified in the relevant legislation, including that in considering whether to involuntarily detain a person, the risk they pose to others is an important factor. Recognition of such a duty in the United States has proven to be workable.

C *Other Legislation*

Legislation in the slightly different context of preventive detention of past sex offenders also gives us some cause for reflection here. (This comparison is not intended to equate those prisoners who have been convicted of a crime, and those who are suffering from mental illness; however some features of legislation in the context of convicted sex offenders are considered relevant). Several states have legislation permitting the court to make an order continuing the incarceration of a past sex offender, based on a psychiatric assessment of the likelihood that the offender will re-offend. For instance, s11 of the *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) provides for a psychiatrist's report in relation to an application for continued detention of a convicted sex offender past the date upon which they would otherwise be eligible for release. Section 11(2) indicates the psychiatrist's report *must* indicate the level of risk that the

¹²⁴ Lord Wright declared the common law way was to go 'from case to case, like the ancient Mediterranean mariners, hugging the coast from point to point, and avoiding the dangers of the open sea of system or science': (1938) 54 *Law Quarterly Review* 185, 186; *Perre v Apand Pty Ltd* (1999) 198 CLR 180, 216-217 (McHugh J).

offender will commit another serious sexual offence if released. Similarly, s6(3)(b) of the *Crimes (High Risk Offenders) Act 2006* (NSW) requires a report of a qualified psychiatrist, registered psychologist or registered medical practitioner which includes the likelihood of the offender committing further sex offences.

Two observations can be made regarding these provisions. Here I put aside important arguments regarding the accuracy with which psychiatrists can in fact predict future behaviour, a hotly contested debate upon which it is not necessary to dwell for current purposes.¹²⁵ Firstly, they reflect that psychiatrists are routinely called upon to make an assessment regarding a person's likely future conduct, including likely wrongdoing that will harm others. As a result, recognition of a duty of care in the circumstances in *Hunter* would not impose on relevant persons a responsibility for which their training makes them unprepared or unqualified. The American research evidence referred to above supports this, where psychiatrists surveyed indicated the question of public safety was always paramount in the minds of decision makers considering involuntary detention.

Secondly, this type of legislation requires courts to balance the report of the psychiatric experts with other factors, including (specifically) public safety.¹²⁶ The courts have not found it impossible to balance a range of factors, including the general expectation that a person who has served the full jail term to which they have been sentenced would be freed, public safety, possible re-offending, whether the person has been rehabilitated etc. No-one says it is easy for a decision maker to balance this range of factors in particular cases, but the legislation clearly contemplates this kind of balancing exercise will occur in this space. Given this, it does not seem unreasonable to expect a psychiatrist dealing with legislation permitting them to involuntarily detain a person (expressly as a last resort) to have regard to public safety and the risk that the person already detained or whom could possibly be detained under the legislation will offend unless detained, in making their deliberations. In applying this duty of care, the court would of course take into account that the legislation specifically states that involuntary detention of someone suffering a mental illness is to be used as a last resort. This feature of the legislation should shape the scope and context of the duty of care owed; it should not preclude it.¹²⁷

¹²⁵ Bernadette McSherry 'Sex, Drugs and 'Evil' Souls: The Growing Reliance on Preventive Detention Regimes' (2006) 32(2) *Monash University Law Review* 237, 268-269.

¹²⁶ S13(4)(i) *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld); s9(3)(a) *Crimes (High Risk Offenders) Act 2006* (NSW).

¹²⁷ 'Proper application of the least restrictive principle should be incorporated in, but not dominate, the evaluation of whether a proper basis for involuntariness was present and therefore whether a reasonable psychiatrist in the psychiatrist's position would have taken the precaution of imposition or maintenance of the person's involuntary inpatient status': Ian Freckelton 'Legal

D *Other Matters in Brief*1 *Claim for Psychiatric Illness*

The case could have called for further consideration of the circumstances in which a claim for psychiatric illness could succeed, given that was the nature of the claim of the plaintiffs. Obviously that has been an area of difficulty for the common law in the past.¹²⁸ However, the defendants in the case did not dispute that the plaintiffs had suffered a recognised psychiatric illness of the required kind.¹²⁹ Nor did they argue that the injury suffered was outside what could have been foreseen would be suffered by a person of ‘normal fortitude’.¹³⁰ As a result, these issues did not need to be, and were not, argued at any point, so further discussion of this issue is not considered necessary for current purposes.¹³¹

2 *Whether any Duty of Care was Breached*

The High Court did not consider this issue, because in its view there was no duty of care owed. Macfarlan JA in the New South Wales Court of Appeal outlined the reasons for his conclusion that the defendant had breached its duty of care to the plaintiffs, primarily based on the medical evidence discussed earlier. As I agree with Macfarlan JA on this point for the reasons he provides,

Liability for Psychiatrists’ Decisions About Involuntary Inpatient Status for Mental Health Patients’ (2014) 22 *Journal of Law and Medicine* 280, 289. This reflects the position of Gaudron McHugh and Gummow JJ in *Brodie* (see discussion around footnote 52).

¹²⁸ *Chester v Waverley Corp* (1939) 62 CLR 1; *Jaensch v Coffey* (1984) 155 CLR 549; *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310; *Tame v New South Wales* (2002) 211 CLR 317; all of these cases must now be read in light of applicable civil liability legislation, for example ss27-33 *Civil Liability Act 2002* (NSW).

¹²⁹ S31 and s33 *Civil Liability Act 2002* (NSW); *Simon and Another v Hunter and New England Local Health District; McKenna v Hunter and New England Local Health District* [2012] NSWDC 19, [6](Elkheim SC DC)(‘Simon’). Obviously a mother and sisters are close family members for the purposes of s30 of the New South Wales Act. Equivalent provisions exist in most other jurisdictions: s72(1) *Wrongs Act 1958* (Vic); s33(1) *Civil Liability Act 1936* (SA); s58(1) *Civil Liability Act 2002* (WA); s34(1) *Civil Liability Act 2002* (Tas); s34(1) *Civil Law (Wrongs) Act 2002* (ACT).

¹³⁰ S32 *Civil Liability Act 2002* (NSW); *Simon* [6]; as a result, it is not considered appropriate to discuss the factors in s32(2) in any depth here.

¹³¹ For further consideration of this issue, see Peter Handford ‘When the Telephone Rings: Restating Negligence Liability for Psychiatric Illness’ (2001) 23 *Sydney Law Review* 597; Peter Handford ‘Psychiatric Injury: The New Era’ (2003) 11 *Tort Law Review* 13; Margaret Fordham ‘Psychiatric Injury, Secondary Victims and the Sudden Shock Requirement (2014) *Singapore Journal of Legal Studies* 41; Danuta Mendelson ‘Psychiatric Injury Law in England and Australia – Drawing Closer Together?’ (2007) 15 *Journal of Law and Medicine* 176; Ian Freckelton ‘Compensation for Pure Psychiatric Injury: Resolution from the Australian High Court?’ (2002) 10 *Journal of Law and Medicine* 133.

it is not considered necessary to discuss the question of breach in any depth.

3 Causation

Another possibly contentious issue could be whether anything the defendant did caused the plaintiff's recognised psychiatric illness. However, while the trial judge did discuss causation, this was on the basis agreed to by both parties that the same principles were to apply to a claim by Rose, as to a claim by Rose's family. As indicated, it is not my belief that this approach was correct, and I respectfully agree with the High Court's ambivalence on this. It is considered to be more difficult for a person like the plaintiffs here, who have suffered psychiatric illness, to show their injuries were caused by the hospital's negligence, than it would be if Rose, say, were merely injured and not killed on the journey, and wished to claim. He would more readily have been able to show his injuries were caused by the hospital's negligence. I will not consider the causation issue further here, since the trial judge's finding that causation did not exist was overturned by the Court of Appeal. The High Court did not consider the issue, given its finding that a duty of care was not owed.

4 Questions of Public Policy

For a time, the test applied to determine cases of alleged negligence explicitly considered whether questions of public policy negated the existence of a duty of care.¹³² The High Court rejected that approach in *Sutherland Shire Council v Heyman*,¹³³ but there is still sporadic express reference to policy in the case law,¹³⁴ and it is possible that some justices are implicitly having regard to such matters in reaching their conclusions. Some of the civil liability statutes make express reference to such matters, at least in the context of public authorities.¹³⁵ Clearly policy factors are still relevant in the United Kingdom in this area.¹³⁶

¹³² *Anns v Merton London Borough Council* [1978] AC 728.

¹³³ (1984) 157 CLR 424, 465 (Mason J), 481 (Brennan J), 508 (Deane J); Gibbs CJ and Wilson J dissenting. In the case of *Stuart and Another v Kirkland-Veenstra and Another* (2008) 237 CLR 215 (a High Court case involving an allegation against police for failing to exercise a power), there is no mention in any of the judgments about policy considerations that arise with respect to claims against police, in sharp contrast to the United Kingdom case law where consideration of policy has been significant in this context.

¹³⁴ Eg *Crimmins v Stevedoring Committee* (1999) 200 CLR 1, 39 (McHugh J); *Graham Barclay Oysters v Ryan* (2002) 211 CLR 540, 578 (McHugh J); policy concerns underlie the High Court's maintenance of barrister immunity from suit: *D'Orta-Ekenaike v Victoria Legal Aid* (2005) 223 CLR 1.

¹³⁵ *Civil Liability Act 2002* (NSW) Part 5; *Wrongs Act 1958* (Vic) Part 12; *Civil Liability Act 2003* (Qld) Chapter 2 Part 3; *Civil Liability Act 2002* (WA) Part 1C; *Civil Liability Act 2002* (Tas) Part 9; *Civil Law (Wrongs) Act 2002* (ACT) Chapter 8.

¹³⁶ A recent example appears in *Michael and Ors v Chief Constable of South Wales Police and Anor* [2015] UKSC 2, [122], explicitly discussing the financial consequences if police were held to owe a duty of care to victims of crime.

To the extent public policy is and should be relevant here, it is worth recalling the sentiment of Sir Thomas Bingham MR in *X (Minors) v Bedfordshire County Council*¹³⁷ to the effect that the rule of public policy which has first claim on the loyalty of the law is that wrongs should be remedied. Clearly, there is strong public interest in upholding high standards in medical endeavours, and legal principle should reflect community expectations.¹³⁸ Individuals expect governments to take reasonable steps to protect their safety. When a duty of care is imposed on virtually all other professionals, it is hard to justify what effectively seems like a new immunity¹³⁹ in the area of mental health service providers. Recognition that a duty of care exists can have positive benefits in terms of encouraging high standards and appropriate care within a particular field; the opposite also holds.¹⁴⁰ This point has been the subject of a quantitative study.¹⁴¹

¹³⁷ [1995] 2 AC 633.

¹³⁸ *Rogers v Whitaker* (1992) 175 CLR 479.

¹³⁹ Indeed, the general trend has been towards abolishing immunities from suit rather than creating more (*Brodie v Singleton Shire Council* (2001) 206 CLR 512), though some traditional immunities remain, at least in Australia: *D'Orta-Ekenaike v Victoria Legal Aid* (2005) 223 CLR 1.

¹⁴⁰ Ian Freckelton 'Legal Liability for Psychiatrists' Decisions About Involuntary Inpatient Status for Mental Health Patients' (2014) 22 *Journal of Law and Medicine* 280, 289: 'protection from liability in negligence extended to psychiatrists (and ... hospitals) ... in (*Hunter*) and *Presland* ... has gone beyond what is defensible in terms of legal principle, creates a category of lack of accountability that is not conceptually or clinically justified, and may well have undesirably counter-therapeutic consequences'; Ian Freckelton 'Liability of Psychiatrists for Failure to Certify: *Presland v Hunter Area Health Service and Dr Nazarian* [2003] NSWSC 754' (2003) 10(2) *Psychiatry, Psychology and Law* 397, 403.

¹⁴¹ Lucinda Platt, Maurice Sunkin and Kerman Calvo 'Judicial Review Litigation as an Incentive to Change in Local Authority Public Services in England and Wales' (2010) 20(2) *Journal of Public Administration Research* 243, who concluded that litigation could act as a 'modest driver to improvements in local government services'; the Law Commission also reflected on the potential positive benefits to litigation, in the context of recommendations to streamline the law with respect to public authority liability in private law: *Administrative Redress: Public Bodies and the Citizen* [2010] EWLC 322, para 4.27.