HIGH COURT OF AUSTRALIA

FRENCH CJ,
HAYNE, BELL, GAGELER AND KEANE JJ

Matter No S142/2014

HUNTER AND NEW ENGLAND LOCAL HEALTH DISTRICT — APPELLANT

AND

MERRYN ELIZABETH MCKENNA — RESPONDENT

Matter No S143/2014

HUNTER AND NEW ENGLAND LOCAL HEALTH DISTRICT — APPELLANT

AND

SHEILA MARY SIMON & ANOR — RESPONDENTS

Hunter and New England Local Health District v McKenna
Hunter and New England Local Health District v Simon
[2014] HCA 44
12 November 2014
S142/2014 & S143/2014

ORDER

Matter No S142/2014

1. *Appeal allowed.*

2. *Set aside paragraphs 2, 3 and 4 of the order of the Court of Appeal of the Supreme Court of New South Wales made on 23 December 2013 and, in their place, order that the appeal to that Court be dismissed.*

3. *The appellant pay the respondent's costs of the appeal to this Court.*

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3. *The appellant pay the respondents' costs of the appeal to this Court.*

On appeal from the Supreme Court of New South Wales

Representation

R J Cheney SC with N E Chen for the appellant (instructed by TressCox Lawyers)

B M Toomey QC with G R Graham for the respondents (instructed by T D Kelly & Co)

CATCHWORDS

Hunter and New England Local Health District v McKenna
Hunter and New England Local Health District v Simon

Negligence – Duty of care – Statutory duties – *Mental Health Act* 1990 (NSW) provided for admission and detention of mentally ill persons in hospital – Act prohibited detention or continuation of detention of mentally ill person in hospital unless medical superintendent formed opinion that no other care of less restrictive kind appropriate and reasonably available – Alleged negligence of hospital and medical staff in discharging mentally ill person – Whether hospital and medical staff owed common law duty of care to protect other persons against harm caused by mentally ill person upon discharge – Whether duties under Act inconsistent with common law duty of care.

Words and phrases – "duty of care", "inconsistent duties", "mentally ill person".

Mental Health Act 1990 (NSW), Ch 4, Pt 2, Div 1.

1 FRENCH CJ, HAYNE, BELL, GAGELER AND KEANE JJ. Phillip Pettigrove was from Echuca, Victoria. He had a long history of chronic paranoid schizophrenia and was being treated for his illness at Echuca. In July 2004, while in New South Wales with a friend, Mr Stephen Rose, Mr Pettigrove was involuntarily admitted to, and detained in, the Manning Base Hospital at Taree ("the Hospital") under Div 1 of Pt 2 of Ch 4 of the *Mental Health Act* 1990 (NSW). Dr Warwick Coombes, a psychiatrist who saw Mr Pettigrove at the Hospital, recorded that he was of the opinion that Mr Pettigrove was a "mentally ill person"[1]. The medical superintendent of the Hospital, Dr Kay Wu, certified[2] that she was of the opinion that Mr Pettigrove was a "mentally ill person".

2 On the day Mr Pettigrove was admitted to the Hospital, the Hospital obtained, and Dr Coombes read, Mr Pettigrove's medical records from the Echuca Community Mental Health Service. Dr Coombes spoke with Mr Pettigrove, Mr Pettigrove's mother and Mr Rose. All agreed that Mr Pettigrove would be kept in the Hospital overnight and that Mr Rose would then drive with Mr Pettigrove to his mother's home in Echuca, where he would receive continuing medical treatment.

3 As proposed, Mr Pettigrove was discharged from the Hospital on the following day. Mr Rose picked him up at the Hospital and they set off to travel by car to Echuca. In the course of that journey, Mr Pettigrove killed Mr Rose. He told police that he had acted on impulse, believing that Mr Rose had killed him in a past life. Mr Pettigrove later took his own life.

4 There was no dispute that the appellant ("the Health Authority") is responsible for the conduct of the Hospital and its medical staff. Did either or both of the Hospital and Dr Coombes owe Mr Rose, or his relatives, a duty of care that was breached by discharging Mr Pettigrove into the company of Mr Rose?

The course of proceedings

5 Two proceedings were brought in the District Court of New South Wales for damages for psychiatric injury allegedly suffered by relatives of Mr Rose as a result of his death: one proceeding brought by a sister of Mr Rose and a separate proceeding brought by the mother and another sister of Mr Rose. The claims

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

2 s 29.

made in the proceedings were not materially different and the two proceedings were tried together. Although there are separate appeals to this Court in each matter, it is convenient to deal with them together and to refer to the plaintiffs, together, as "the relatives".

6 In the District Court, the relatives alleged that Dr Coombes and the Hospital did not exercise reasonable professional care and skill in deciding that Mr Pettigrove could leave the Hospital with Mr Rose for the purpose of Mr Rose taking Mr Pettigrove back to the place in Victoria where he could be treated by his usual treating doctors. The trial judge, Elkaim DCJ, recorded that the relatives put their case on the basis that the discharging of Mr Pettigrove from the Hospital, of itself, was not negligent. Rather, their case was that placing Mr Pettigrove into Mr Rose's care for the road trip was the act of negligence. And the trial judge recorded that the real dispute between the parties was whether there was a breach of duty.

7 The trial judge found that there had been no breach of duty and entered judgment in both proceedings for the Health Authority. The trial judge based his conclusions about breach of duty on the application of the *Civil Liability Act* 2002 (NSW) ("the CLA"). His Honour held that s 5B(1)[3] of the CLA was engaged because it was not shown that "a reasonable person in Dr Coombes' position would have concluded that there was a not insignificant risk of Mr Pettigrove behaving as he did". His Honour further found that s 5O[4] of that

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3 "A person is not negligent in failing to take precautions against a risk of harm unless:

(a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known), and

(b) the risk was not insignificant, and

(c) in the circumstances, a reasonable person in the person's position would have taken those precautions."

4 "(1) A person practising a profession (***a professional***) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

(Footnote continues on next page)

Act also applied and that Dr Coombes had acted "in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice"[5].

8 The relatives appealed to the Court of Appeal of the Supreme Court of New South Wales. The Court of Appeal (Beazley P and Macfarlan JA, Garling J dissenting) allowed[6] the relatives' appeals and ordered that there be judgments for the relatives.

9 Beazley P held[7] that the Health Authority owed Mr Rose "a duty of care not to release [Mr Pettigrove], who was a mentally ill person, into Mr Rose's care, or at least his sole care, for the purposes of conveying him to Victoria where it was intended or, at least, expected that he would undergo further psychiatric treatment". Macfarlan JA held[8] that "[t]he Hospital owed Mr Rose a common law duty to take reasonable care to prevent Mr Pettigrove causing physical harm to Mr Rose"; that Dr Coombes was negligent "in discharging Mr Pettigrove from the Hospital" when he did; that the Health Authority "is not entitled to the protection of s 5O" of the CLA[9]; and that Dr Coombes' negligence

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(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

(3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.

(4) Peer professional opinion does not have to be universally accepted to be considered widely accepted."

5 s 5O(1).

6 *McKenna v Hunter and New England Local Health District* (2013) Aust Torts Reports ¶82-158.

7 (2013) Aust Torts Reports ¶82-158 at 67,001 [2].

8 (2013) Aust Torts Reports ¶82-158 at 67,002 [10].

9 Macfarlan JA also rejected arguments that two other provisions of the CLA (ss 43 and 43A), concerning the exercise of statutory powers by public or other authorities, were engaged: (2013) Aust Torts Reports ¶82-158 at 67,002 [10].

was a cause of the injuries which Mr Rose, and therefore his mother and sisters, suffered.

10 By special leave, the Health Authority appeals to this Court in each matter. Each appeal should be allowed. Consistent with the terms on which special leave was granted, the Health Authority should pay the costs of each appeal and the costs orders made by the Court of Appeal should not be disturbed. Orders 2, 3 and 4 made by the Court of Appeal in each matter should be set aside and in their place there should be orders that each appeal to the Court of Appeal is dismissed.

Argument of the appeal

11 In this Court, the Health Authority alleged many grounds of appeal. It alleged that the Court of Appeal was wrong to hold that it (or, more accurately, the Hospital or Dr Coombes) owed a duty of care to Mr Rose and his relatives. It raised issues about the application of s 5B of the CLA and breach of duty, s 5O of the CLA and "competent professional practice", s 43 of the CLA and liability for breach of a statutory duty, and s 43A of the CLA and the "exercise of special statutory powers". The parties filed written submissions directed to all of these issues.

12 At the hearing of the appeals, the Court required the parties to make oral submissions about only the question of duty of care. The other issues raised by the Health Authority do not fall for consideration if, as these reasons will show, the Hospital and Dr Coombes did not owe the relatives a duty of care. Consideration of those other issues, about ss 5B, 5O, 43 and 43A of the CLA, should await a case in which it is necessary to examine them.

Duty to whom?

13 In the Court of Appeal, the Health Authority contended that judgment was properly entered in its favour in each proceeding because the Hospital and Dr Coombes owed no relevant duty of care. (It will be recalled that the trial judge decided the cases on the basis that there was no breach of duty.) The Health Authority argued that it owed no relevant duty of care to the relatives because the Hospital and Dr Coombes did not owe Mr Rose a duty to take reasonable care to avoid Mr Pettigrove inflicting physical injury on Mr Rose. In his reasons for judgment, Macfarlan JA recorded[10] that the Health Authority did

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10 (2013) Aust Torts Reports ¶82-158 at 67,022 [85].

not argue "that even if the Hospital owed a relevant duty of care to Mr Rose, it nevertheless did not owe such a duty to the [relatives], who were members of his family".

14 Argument having taken this course in the Court of Appeal, there was no exploration in argument, in either that Court[11] or this, of how a finding that the Hospital or Dr Coombes owed a duty of care to Mr Rose bears upon whether it or he owed a duty of care to the relatives. The hypothesised duties are owed to different persons and are duties to take reasonable care to prevent a third party doing something that would cause different kinds of injury: in the case of Mr Rose, physical injury; in the case of the relatives, psychiatric injury.

15 It is not necessary, however, to decide whether the two different duties are related[12] in the manner assumed in argument in the Court of Appeal. That is, it is not necessary to decide whether the Court of Appeal was right to conclude that, because the Hospital and Dr Coombes owed Mr Rose a duty to take reasonable care to prevent Mr Pettigrove inflicting physical harm on him, they also owed the relatives a duty to take reasonable care to prevent psychiatric injury sustained on learning that Mr Pettigrove had killed Mr Rose. Nothing in these reasons should be understood as deciding that point.

16 It is also not necessary to consider the extent and potential indeterminacy of the liability which imposing the alleged duty of care would entail. If, as the relatives submitted, the Hospital and Dr Coombes owed Mr Rose and his relatives a duty of care, it is not easy to see why that duty did not extend to any and every person with whom Mr Pettigrove would come in contact after his release from the Hospital. The range of persons who might foreseeably suffer harm if Mr Pettigrove acted violently was extensive[13].

Difficulties in determining the existence of a duty

17 In *Sullivan v Moody*[14] this Court pointed out why determining the existence and nature and scope of a duty of care may be difficult. Four examples

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11 cf (2013) Aust Torts Reports ¶82-158 at 67,040 [206] per Garling J.

12 cf *Tame v New South Wales* (2002) 211 CLR 317 at 399-400 [243]-[246]; [2002] HCA 35.

13 cf *Sullivan v Moody* (2001) 207 CLR 562 at 582 [61]; [2001] HCA 59.

14 (2001) 207 CLR 562.

were given of classes of case in which particular difficulty may arise. The Court said[15]:

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

18 The examples given in *Sullivan* were all based on particular decisions of this Court. It is useful to amplify the references given in *Sullivan* in the way Gummow J did in *Vairy v Wyong Shire Council*[16]. In *Sullivan*, the Court referred to *Modbury Triangle Shopping Centre Pty Ltd v Anzil*[17] as an example of the first problem (nature of harm). It referred to *Crimmins v Stevedoring Industry Finance Committee*[18] and *Brodie v Singleton Shire Council*[19] (to which may be added *Graham Barclay Oysters Pty Ltd v Ryan*[20]) as examples of the second problem (statutory power). It referred to *Perre v Apand Pty Ltd*[21] (to which may be added *Woolcock Street Investments Pty Ltd v CDG Pty Ltd*[22]) as an example of

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15 (2001) 207 CLR 562 at 579-580 [50].

16 (2005) 223 CLR 422 at 448 [78]; [2005] HCA 62.

17 (2000) 205 CLR 254; [2000] HCA 61.

18 (1999) 200 CLR 1; [1999] HCA 59.

19 (2001) 206 CLR 512; [2001] HCA 29.

20 (2002) 211 CLR 540; [2002] HCA 54.

21 (1999) 198 CLR 180; [1999] HCA 36.

22 (2004) 216 CLR 515; [2004] HCA 16.

the third problem (indeterminacy of class). It referred to *Hill v Van Erp*[23] (to which may be added *Koehler v Cerebos (Australia) Ltd*[24]) as an example of the fourth problem (coherence). Each of those decisions demonstrates that questions of duty of care may present difficult issues.

19 Every one of the four examples given in *Sullivan* was relevant in this matter. The relatives' claims presented issues about the nature of harm, about the exercise of statutory powers and discretions, about indeterminacy of class and about coherence. These reasons will show that the second of those considerations, statutory power, is determinative. But that conclusion should not be understood as suggesting that the other three considerations which have been mentioned (nature of harm, indeterminacy and coherence) are not relevant considerations bearing upon whether the Hospital or Dr Coombes owed the relatives a relevant duty of care.

20 Proper determination of whether there was a relevant duty of care and, if there was, of the nature and scope of that duty is not assisted by directing attention only to why the relatives suffered the injuries they did. The relatives sustained psychiatric injury on learning of Mr Rose's death at the hand of Mr Pettigrove. Their complaint was that Mr Pettigrove should not have been allowed to leave the Hospital, or at least not in the company of Mr Rose because there was a risk that Mr Pettigrove would do (physical) injury to Mr Rose. And they alleged that Dr Coombes and the Hospital did not act with reasonable care and skill when deciding whether Mr Pettigrove could leave the Hospital to travel to Echuca with Mr Rose.

21 As will be recalled, the relatives submitted at trial that the relevant act of negligence was placing Mr Pettigrove into the care of Mr Rose. The relatives sought to distinguish that conduct from what was described as the decision to discharge Mr Pettigrove. It is greatly to be doubted that any distinction of the kind described can be made in this case. But whether or not that is so, specification of the respect or respects in which the relatives said that the Hospital or Dr Coombes did not act with reasonable care should not distract attention from the need to identify the duty which it is alleged was owed to the relatives: a duty to take reasonable care when deciding that the powers given by

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23 (1997) 188 CLR 159 at 231; [1997] HCA 9.

24 (2005) 222 CLR 44; [2005] HCA 15.

the *Mental Health Act*, which had been used to detain Mr Pettigrove, should no longer be used to prevent him leaving the Hospital.

22 Identifying whether there was such a duty (and if there was, its nature and scope) requires consideration of the *Mental Health Act.* Would a duty of care to the relatives be consistent with the provisions of the *Mental Health Act*?

23 Consideration of this question must begin with an examination of the relevant provisions of the *Mental Health Act.*

Mental Health Act

24 Section 4(2)(b) of the *Mental Health Act* provided that "[i]t is the intention of Parliament" that the Act be interpreted, and "every function, discretion and jurisdiction conferred or imposed" by the Act be, as far as practicable, performed or exercised, so that (among other things) "any restriction on the liberty of patients and other persons who are mentally ill or mentally disordered and any interference with their rights, dignity and self-respect are kept to the minimum necessary in the circumstances". Consistent with this general principle, the provisions of Div 1 of Pt 2 of Ch 4 of the Act (ss 20-37A) limited the powers to detain a person in hospital.

25 Section 20 provided that:

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

That is, the *Mental Health Act* prohibited detention, or the continuation of detention, unless the medical superintendent of the hospital formed the opinion that *no* other less restrictive care was appropriate and reasonably available.

26 This prohibition was reinforced by other provisions of the *Mental Health Act* including, among others, ss 28, 29 and 35. Section 29 required prompt examination by the medical superintendent of a person detained in a hospital. Section 28 obliged the medical superintendent to refuse to detain a person unless the superintendent was of the opinion that the person was a mentally ill person or a mentally disordered person. Section 35(3) required that a person not be further detained in a hospital if the medical superintendent was of the opinion either that the person was not a mentally ill person or a mentally disordered person or that "other care of a less restrictive kind is appropriate and reasonably available to the person".

27 These features of the Act presented a medical superintendent of a hospital deciding whether a person should be, or should continue to be, involuntarily admitted and detained with two questions. First, is the person a mentally ill person or a mentally disordered person? Second, if yes, is there *no* other care of a less restrictive kind which is appropriate and reasonably available to the person?

28 No doubt, each question required clinical assessment and judgment, and each had to be answered either yes or no. But if the person was judged to be a mentally ill person, the Act required not only that "any restriction on the liberty [of that person] and any interference with their rights, dignity and self-respect [be] kept to the minimum necessary in the circumstances"[25], but also that, *unless* the medical superintendent was of the opinion that no other care of a less restrictive kind was appropriate and reasonably available, the person not be detained or further detained. Hence, determining that a person was a "mentally ill person" did not entail that the person must be, or must continue to be, involuntarily admitted to and detained in a hospital.

Inconsistent duties

29 The core of the relatives' complaint in this matter is that each was injured because a decision was made not to continue to detain a mentally ill person. But, as in *Sullivan*[26], those who made that decision had other duties. Particularly relevant was the obligation imposed by s 20 not to detain or continue to detain a person unless the medical superintendent was of the opinion that no other care of a less restrictive kind was appropriate and reasonably available to the person. Performance of that obligation would not be consistent with a common law duty of care requiring regard to be had to the interests of those, or some of those, with whom the mentally ill person may come in contact when not detained. And, as explained[27] in *Sullivan*, "if a suggested duty of care would give rise to inconsistent obligations, that would ordinarily be a reason for denying that the duty exists".

30 If a hospital or doctor were to owe to those with whom a mentally ill person may later come in contact a duty to take reasonable care to protect those

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25 s 4(2)(b).

26 (2001) 207 CLR 562 at 581 [55]-[56].

27 (2001) 207 CLR 562 at 582 [60].

others from risk of physical harm (or psychiatric injury caused by learning of physical harm) done by the mentally ill person, the hospital or doctor would be required to ask whether that risk is foreseeable and not insignificant and then take whatever steps a reasonable person would take in response to that risk. Foreseeable risks are those that are not far-fetched or fanciful[28].

31 If a person is a mentally ill person, the risk of that person acting irrationally will often not be insignificant, far-fetched or fanciful. And, in such cases, there will often be a risk[29] that the irrational action will have adverse consequences. In some cases, there will be a risk that the mentally ill person will engage in conduct that may have adverse physical consequences for others, whether because the conduct is directed at another or because it otherwise causes adverse physical consequences. In some cases, perhaps many, the reasonable person in the position of the hospital or doctor would respond to those risks by continuing to detain the patient for so long as he or she remains a mentally ill person, thus avoiding the possibility that the risk of harm to others will eventuate. But that is not what the *Mental Health Act* required. It required the *minimum* interference with the liberty of a mentally ill person. It required[30] that the person be released from detention unless the medical superintendent of the hospital formed the opinion that no other care of a less restrictive kind was appropriate and reasonably available to that person.

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

33 The powers, duties and responsibilities of doctors and hospitals respecting the involuntary admission and detention of mentally ill persons were prescribed

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28 *Wyong Shire Council v Shirt* (1980) 146 CLR 40 at 48 per Mason J; [1980] HCA 12.

29 Section 9 of the *Mental Health Act* defined a "mentally ill person" in terms that required (among other things) "reasonable grounds for believing that care, treatment or control of the person [was] necessary ... for the person's own protection from serious harm, or ... for the protection of others from serious harm".

30 s 20.

by the *Mental Health Act*. It is the provisions of that Act which identified the matters to which doctors and hospitals must have regard in exercising or not exercising those powers. Those provisions are inconsistent with finding the common law duty of care alleged by the relatives.

Conclusion

34 This being so, it is not necessary to consider the extent and potential indeterminacy of the liability which imposing a duty of care would entail. Nor is it necessary to consider the difficulties presented in this case by the immediate cause of the harm suffered by the relatives being occasioned by the unlawful act of Mr Pettigrove. And, as already explained, the issues about the application of ss 5B, 5O, 43 and 43A of the CLA are not reached.

35 The Hospital and Dr Coombes did not owe the relatives a relevant duty of care. The appeals must be allowed and consequential orders made.