CITATION:	*AX v Mental Health Review Tribunal & Anor* [2019] NTSC 34
PARTIES:	AX v MENTAL HEALTH REVIEW TRIBUNAL and NORTHERN TERRITORY OF AUSTRALIA
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT exercising Territory jurisdiction
FILE NO:	LCA 39 of 2018 (21828719)
DELIVERED:	17 May 2019
HEARING DATES:	5 October 2018
JUDGMENT OF:	Blokland J

CATCHWORDS:

EVIDENCE – appeal of decision of Mental Health Review Tribunal – second respondent sought to admit expert report prepared by psychiatrist after Tribunal hearing – whether report admissible – appeal pursuant to s 142(3) *Mental Health and Related Services Act* (NT) is by way of rehearing – rehearing can be distinguished from appeal de novo – Court cannot receive further evidential material that was not before the Tribunal without substantial reason being advanced – new source material not available to Tribunal was relied on to prepare report – report inadmissible.

APPEAL – Mental Health Review Tribunal – appeal against decision by Tribunal to make Community Management Order – whether Tribunal erred by finding appellant was unable to give informed consent to care or treatment under s 16(b)(iii) *Mental Health and Related Services Act* (NT) – whether Tribunal failed to apply the *Briginshaw* standard of proof – where psychiatrist considered appellant had capacity to consent at time of hearing but Form 15 recommended further Community Management Order – where evidence of fluctuating compliance with medication and detrimental consequences when the appellant became unwell as a result of non-compliance – Tribunal not obliged to accept evidence of psychiatrist or appellant at hearing – Tribunal informed by direct evidence of appellant's history of non-compliance – Tribunal's finding open on material – appeal dismissed.

APPEAL – Mental Health Review Tribunal – appeal against decision by Tribunal to make Community Management Order – whether failure to provide the appellant with adverse information from Tribunal file amounted to a denial of procedural fairness – appellant had prior notice the Tribunal was in possession of historical material – appeal dismissed.

APPEAL – Mental Health Review Tribunal – appeal against decision by Tribunal to make Community Management Order – whether Tribunal erred by failing to take into account principles in s 8 *Mental Health and Related Services Act* (NT) – whether the appellant's dignity and self-respect were not considered by Tribunal – purpose of *MHRSA* is to ensure the integrity of treatment and the rights of people with mental illness but also to neutralise risk of harm – given appellant lacked capacity to consent to medical treatment or care CMO was likely the least restrictive option in the circumstances – appeal dismissed.

Evidence (National Uniform Legislation) Act (NT) ss 3, 4; *Mental Health Act* 2014 (Vic) s 68(2)(b); *Mental Health and Related Services Act* (NT) ss 3, 6, 7(2), 7(3), 8, 8(a), 8(b), 16, 16(b)(iii), 123(5)(c), 133(3), 142(1), 142(3); *Supreme Court Act* (NT) s 22(4)(b)(iii); *Supreme Court Rules* (NT) rr 83.20, 83.20(2)

Allesch v Maunz [2000] HCA 40; 203 CLR 172, *Briginshaw v Briginshaw* [1938] HCA 34; 60 CLR 336, CH *v Mental Health Review Tribunal & Anor* [2017] NTSC 43; 320 FLR 417, *Coal and Allied Operations Pty Ltd v Australian Industrial Relations Commission* [2000] HCA 47; 203 CLR 194,

Crampton v The Queen (2000) 206 CLR 161, *JXC v Mental Health Review Tribunal & Anor* [2018] NTSC 62, *Kioa v West* [1985] HCA 81; 159 CLR 550, *McLaren v Legal Practitioners Disciplinary Tribunal & Anor* [2010] NTSC 2; 26 NTLR 45, *Minister for Immigration and Border Protection v WZARH* [2015] HCA 40; 256 CLR 326**,** *Minister for Immigration Local Government and Ethnic Affairs v Kurtovic* (1990) 21 FCR 193, *Re Refugee Review Tribunal*; *Ex parte Aala* [2000] HCA 57; 204 CLR 82, *Stead v State Government Insurance Commission* [1986] HCA 54; 161 CLR 141, *SZBEL v Minister for Immigration and Multicultural and Indigenous Affairs* [2006] HCA 63; 228 CLR 152, *XWZ* [2016] VMHT 25, referred to.

REPRESENTATION:

Counsel:

Appellant:	G Gilbert SC
First Respondent:	First Respondent submits to the jurisdiction of the Court
Second Respondent:	R E Brebner

Solicitors:

Appellant:	Northern Territory Legal Aid Commission
First Respondent:	Solicitor for the Northern Territory
Second Respondent:	Solicitor for the Northern Territory

Judgment category classification:	B
Judgment ID Number:	BLO1903
Number of pages:	43

IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

AX v Mental Health Review Tribunal & Anor [2019] NTSC 34
LCA 39 of 2018 (21828719)

BETWEEN:

AX
Appellant

AND:

MENTAL HEALTH REVIEW TRIBUNAL
First Respondent

AND:

NORTHERN TERRITORY OF AUSTRALIA
Second Respondent

CORAM: BLOKLAND J

REASONS FOR JUDGMENT

(Delivered 17 May 2019)

Background

[1] This is an appeal against a decision of the Mental Health Review Tribunal ("the Tribunal") made on 4 June 2018. The decision of the Tribunal was to place the appellant on a Community Management Order ("CMO") for a period of six months. The CMO was made pursuant to s 123(5)(c) of the *Mental Health and Related Services Act* (NT) ("*MHRSA*"), which authorises the Tribunal to make a CMO for no longer than six months provided a

person meets certain criteria for involuntary treatment or care in the community. The Tribunal's decision was made, as is the usual case, *ex tempore* at the conclusion of the review hearing on 4 June 2018 ("the hearing").

[2] The appellant claims the Tribunal was in error by making the CMO. The appeal is based on three grounds, which can be summarised as follows:[1]

a) On the evidence available to the Tribunal, it was not open to the Tribunal to make a finding that the Appellant was unable to give informed consent, and as a result, the CMO was made in error. Further, or in the alternative, the Tribunal erred by failing to apply the relevant standard of proof, namely, the test articulated by the High Court in *Briginshaw v Briginshaw* ("*Briginshaw*");[2]

b) The appellant was not provided with material that was adverse to the appellant's claim and was not adequately put on notice as to critical issues forming the basis of the Tribunal's decision, and as a result, the appellant was denied procedural fairness; and

c) In reaching its decision, the Tribunal was obliged to consider and apply the principles contained in s 8 of the *MHRSA*, but failed to do so.

[3] In brief, there has been a long-term diagnosis of schizoaffective disorder with respect to the appellant. From the relevant available material it is evident the appellant has required treatment over many years and in different forms. For example, the appellant has been subject to involuntary treatment orders including detention, community management orders and voluntary treatment in the community. Given the available material before

1 See Amended Notice of Appeal, 14 September 2018; Appellant's submissions of 14 September 2018.

2 [1938] HCA 34; 60 CLR 336.

the Tribunal the appellant argues the finding that she was unable to give informed consent was not open on the evidence, there was a lack of procedural fairness and a failure to properly apply certain standards the Tribunal is required to apply as stipulated by the *MHRSA*.

Legislative framework

[4] Section 16 of the *MHRSA* provides criteria that must be satisfied before a CMO can be ordered. One of those criteria is that 'the person is not capable of giving informed consent to the treatment or care or has unreasonably refused to consent to the treatment or care'.[3] Section 16 reads as follows:

> The criteria for the involuntary treatment and care of a person in the community are:
>
> (a) the person has a mental illness; and
>
> (b) as a result of the mental illness:
>
> (i) the person requires treatment or care; and
>
> (ii) without the treatment or care, the person is likely to:
>
> (A) cause serious harm to himself or herself or to someone else; or
>
> (B) suffer serious mental or physical deterioration; and
>
> (iii) the person is not capable of giving informed consent to the treatment or care or has unreasonably refused to consent to the treatment or care; and

3 *Mental Health and Related Services Act* (NT), s 16(b)(iii).

(c) the treatment or care is able to be provided by a community management plan that has been prepared and is capable of being implemented.

[5] 'Informed consent' is defined in s 7(2) of the *MHRSA* as follows:

> A person gives informed consent under this Act:
>
> (a) when the person's consent is freely and voluntarily given without any inducement being offered; and
>
> (b) the person is capable of understanding the effects of giving consent; and
>
> (c) the person communicates his or her consent on the approved form.

[6] Section 8 of the *MHRSA* provides direction on how the Act is to be interpreted and how the powers conferred by the Act are to be performed. It states:

> This Act is to be interpreted and a power or function conferred or imposed by this Act is to be exercised or performed so that:
>
> (a) a person who has mental health illness receives the best possible care and treatment in the least restrictive and least intrusive environment enabling the care and treatment to be effectively given; and
>
> (b) in providing for the care and treatment of a person who has a mental illness and the protection of members of the public, any restriction on the liberty of the person and any other person who has a mental illness, and any interference with their rights, dignity, privacy and self-respect is kept to the minimum necessary in the circumstances; and
>
> (c) the objective of treatment is directed towards the purpose of preserving and enhancing personal autonomy; and

(d) the administration of medication to a person serves the best interests and health needs of the person and is administered only for the therapeutic or diagnostic purposes and not as punishment or for the convenience of others; and

(e) medication to be administered to a person is prescribed only by persons who are authorised by law to do so; and

(f) a person who has a mental illness who needs language, interpreter, advocacy, legal or other services to assist him or her in communicating has access to those services; and

(g) the assessment, care, treatment and protection of an Aboriginal person or a person from a non-English speaking background who has a mental illness is appropriate to, and consistent with, the person's cultural beliefs, practices and mores.

Preliminary issue: admissibility of the report of Dr Large

[7] At the appeal hearing, counsel for the second respondent sought to rely on an expert report that had been prepared by Professor Matthew Large from the University of New South Wales' School of Psychiatry. When commissioning the report, the second respondent asked Professor Large to consider the following questions:[4]

(a) When considering the definition of 'informed consent' at [sic] s 7(2)-(3) of the *MHRSA* and the test set out at s 16(iii) [*MHRSA*], was it open on the evidence before the Tribunal hearing on 4 June 2018 to conclude that [AX] in fact did not have capacity to give informed consent to treatment? Why? Why not?

(b) Please consider s 7(2)&(3) *MHRSA*. Is this definition part of what constitutes a patient's 'insight'? Is insight into their illness something that it used to assess a patient's capacity to give 'informed consent'?

4 Report of Professor Matthew Large dated 26 September 2018 at 3.

(c) Clinically, when assessing a patient's capacity to give informed consent to treatment, is it preferable to make the assessment as at a particular point in time, or over the period of a course of treatment (for example, a Community Management Order operates for a period of not more than 6 months)? Why is that?

[8] The appellant objected to the report in its entirety on the basis it was not admissible. After hearing submissions from both parties it was ordered that Professor Large's report not be admitted in the appeal proceeding for the reasons that follow.

[9] Had Professor Large's report been available to the Tribunal, much of it would no doubt have been helpful given his obvious expertise and the clarity of his opinions and explanations of key issues. Of particular relevance are his opinions expressed in answer to the questions posed as above that bear on whether AX was able to provide informed consent. While a report of this kind would have been helpful and informative before the Tribunal, at first blush it strikes as unusual that such profound expert opinions would be offered for the first time on appeal.

[10] Counsel for the second respondent argued Professor Large's report goes directly to a determination of a legal, factual or discretionary matter as contemplated in the authorities to be discussed further. However, it must be remembered that if a relevant error is identified in the proceedings before the Tribunal, additional evidence, whether that be opinion evidence or otherwise, which was not before the Tribunal will not cure a finding of error. It is accepted the Tribunal possesses specialised expertise and so

far as possible, when hearing the matter on appeal, the Court is to stand in the shoes of the Tribunal. It is accepted counsel for the second respondent's intention by submitting the report was to ensure this Court was appropriately equipped with expert opinion evidence. However, after reviewing the authorities, it would seem the features of proceedings of this kind do not permit the Court to receive further evidential material that was not before the Tribunal without a substantial reason being advanced, save in certain cases concerning procedural fairness or other questions that can only be ventilated by the consideration of further evidence not available before the Tribunal. It is accepted that in the general course the Tribunal's reasons are brief given the nature of the hearings conducted before it and the need for expedition. Consistent with that practice the Tribunal's reasons in this matter were brief, however on appeal this Court is obliged to consider the reasons in the light of the known material before the Tribunal, rather than by supplementing the material with expert evidence beyond was considered at the hearing.

[11] It may be observed that while this is an appeal from a Tribunal which is not itself bound by the rules of evidence,[5] this Court is bound by the rules of evidence. Section 4 of the *Evidence (National Uniform Legislation) Act* (NT) (*"UEA"*) provides the *UEA* applies to all proceedings in a 'Territory Court'. A 'Territory Court' includes the Supreme Court.[6] Ultimately

5 *Mental Health and Related Services Act* (NT), s 133(3).

6 *Evidence (National Uniform Legislation) Act* (NT), s 3 (Dictionary).

however the question of admissibility of the report is not resolved by recourse to the rules of evidence but by examination of the applicable procedures and principles relevant to the question of when a Court may properly receive additional evidence of this kind on an appeal from a Tribunal.

[12] Section 142(1) of the *MHRSA* provides that a person aggrieved by a decision of the Tribunal may appeal that decision to the Supreme Court. Section 142(3) provides that the appeal is to be heard by way of a 'rehearing'. As I have indicated previously,[7] I agree with Hiley J's conclusion in *CH v Mental Health Review Tribunal & Anor*[8] that the nature of an appeal under the *MHRSA* is more restricted than an appeal *de novo*. An appeal under the *MHRSA* can only succeed where errors are identified in the original decision making process. Those errors may be legal, factual or discretionary.[9] On appeal, the Court cannot institute a fresh decision-making process.

[13] The general procedure regulating appeals from the decisions of Tribunals is governed by Part 2 of Order 83 of the *Supreme Court Rules* (NT). Rule 83.20 provides where an appeal is by way of rehearing, either party may call new evidence at the hearing. Rule 83.20 has however been interpreted strictly on the basis of an acknowledgement that the nature of

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7 See *JXC v Mental Health Review Tribunal & Anor* [2018] NTSC 62 at [4].

8 *CH v Mental Health Review Tribunal & Anor* [2017] NTSC 43; 320 FLR 417 at [19]-[20] ('*CH v Mental Health Review Tribunal*').

9 *CH v Mental Health Review Tribunal & Anor* [2017] NTSC 43; 320 FLR 417 at [31].

the appeal is by way of rehearing, rather than *de novo*. In my view the nature of the evidence sought to be admitted by the second respondent may well be appropriate in an appeal *de novo* but the authorities reviewed indicate an appeal by way of rehearing first requires consideration of whether there has been factual or legal error in the original decision based on the material before the original decision maker. Additional evidence may be admitted only when there is likely to be an injustice if the new evidence were not admitted. The admission of new evidence must also be balanced against the public interest in the finality of court decisions.[10]

[14] These issues were explored at length by Hiley J in *CH v Mental Health Review Tribunal*.[11] Notwithstanding there is some difference in the context of how the issue of additional evidence arose in *CH v Mental Health Review Tribunal*, the principles discussed are applicable here. His Honour relied on the following distinction between an appeal by way of rehearing and a hearing *de novo* as stated by Gaudron, McHugh, Gummow and Hayne JJ in *Allesch v Maunz*:[12]

> The critical difference between an appeal by way of rehearing and a hearing de novo is that, in the former case, the powers of the appellate court are exercisable only where the appellant can demonstrate that, having regard to all the evidence now before the appellate court, the order that is the subject of the appeal is the result of some legal, factual or discretionary error, whereas, in the latter case, these powers may be exercised regardless of error. At least that is so unless, in the case of an appeal by way of rehearing, there is

10 *Crampton v The Queen* (2000) 206 CLR 161 at 172-3.

11 [2017] NTSC 43; 320 FLR 417.

12 [2000] HCA 40; 203 CLR 172 at [180]-[181].

some statutory provision which indicated that the powers may be exercised whether or not there was error at first instance.

[15] In *CH v Mental Health Review Tribunal*, it was also emphasized that there is no other statutory power conferred on the Supreme Court to simply review a decision of the Tribunal without regard to whether there was error in the first place. Reference was also made in *CH v Mental Health Review Tribunal* to *Coal and Allied Operations Pty Ltd v Australian Industrial Relations Commission*,[13] particularly with respect to the issue of evidence that may be admitted to show a tribunal erred by failing to allow an appellant to be represented, not permitting the appellant to give relevant evidence, make submissions or other issues that raise a question of procedural fairness or natural justice.[14] Indeed, evidence of this kind has been admitted here by consent, after the parties agreed some portions be removed.[15] That evidence is in support of the procedural fairness ground.

[16] The case of *McLaren v Legal Practitioners Disciplinary Tribunal & Anor*[16] ("*McLaren*") is instructive concerning the question of receiving additional evidence pursuant to s 22(4) of the *Supreme Court Act* (NT). Section 22(4) provides for an appeal by way of rehearing and like r 83.20 provides that on

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13 [2000] HCA 47; 203 CLR 194.

14 *Coal and Allied Operations Pty Ltd v Australian Industrial Relations Commission* [2000] HCA 47; 203 CLR 194 at 203-204.

15 Affidavit of Hannah Kate Quadrio sworn 14 September 2018. Paragraph 11 and a portion of paragraph 12 was excluded by agreement.

16 [2010] NTSC 2; 26 NTLR 45.

the hearing of an appeal the Full Court has the power 'to receive further evidence in a manner the Full Court directs'.[17]

[17] When discussing the nature of an appeal of this kind Martin (BR) CJ agreed with Mildren J[18] to the effect that r 83.20 did not apply to the particular circumstances given the provisions of the *Supreme Court Act* prevailed on the procedure relevant for the discipline of legal practitioners. His Honour Martin (BR) CJ nevertheless made some observations about r 83.20(2). Principally, that r 83.20(2) does not give an unfettered right to call admissible evidence on appeal without leave, and with some qualifications. His Honour said:[19]

> Such an interpretation would give an unfettered right to lead additional evidence on appeal regardless of the circumstances in which the party failed to call the evidence before the Tribunal. A party could deliberately decline to call relevant and cogent evidence before the Tribunal for tactical reasons and await the decision in the knowledge that an appeal could be lodged and the evidence led on appeal. This would be a startling result.
>
> In my view, if order 83 applies, leave is required. In accordance with ordinary principles, the application for leave is required to explain why the evidence was not called before the tribunal and to persuade the court that it is in the interests of justice to permit the evidence to be called on the appeal.

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17 *Supreme Court Act* s 22(4)(b)(iii).

18 *McLaren v Legal Practitioners Disciplinary Tribunal & Anor* [2010] NTSC 2; 26 NTLR 45 at [210]-[216].

19 *McLaren v Legal Practitioners Disciplinary Tribunal & Anor* [2010] NTSC 2; 26 NTLR 45 at [78]-[79].

[18] To be clear, it is not suggested and the issue is not determined on any basis that the second respondent has utilised any tactic, however, in my view the material of the kind sought to be admitted on appeal should have been before the Tribunal, either as part of the psychiatric evidence or the history, including the psychiatric opinion that was made available during the Tribunal hearing. Given the composition of the Tribunal with a psychiatrist member as well as the treating psychiatrist giving evidence, in the ordinary course, it would not be expected that another psychiatrist give evidence, however the material relied on for the opinions sought to be tendered on appeal should have been before the Tribunal in some form.

[19] Importantly, a number of hospital records and progress notes used to inform at least part of the basis of Professor Large's opinion were not before the Tribunal. It is not possible to determine the influence those materials had on Professor Large's conclusions. It would not be fair and not in the interests of justice to hear the appeal on the basis of new source and historical material.[20]

[20] I am not so concerned with the objections raised on behalf of the appellant to opinions such as those expressed in Professor Large's report said to be based on the 'ultimate issue rule'. That rule was abolished in the Northern Territory upon the introduction of the *UEA*. In any event, psychiatrists are often asked to give their opinions by reference to a legal

20 These materials are listed as Items 6, 7 and 8 on page 4 of the report of Professor Matthew Large dated 26 September 2018.

standard, otherwise there would be little point in their expert opinions being received. I would however need to significantly reduce the weight of those of the opinions expressed in a manner that suggests all legal and factual matters lead to a conclusion that a result was 'open' to the Tribunal. That is entirely a matter for the Court once all of the material is considered.

[21] There is no doubt Professor Large possesses the expertise to give evidence of the opinions contained in his report. Evidence of this kind sought to be led on issues of fact may in some circumstances be admitted at an appeal by way of rehearing. However, there is no reason why such evidence or similar material could not have been placed before the Tribunal which is not in any event bound by the rules of evidence. The relevant expert opinion may well be in a different format and possibly drawn from a treating psychiatrist or from the expert psychiatric member of the Tribunal. To allow the evidence to be admitted now would completely blur the lines between appellate review by rehearing and exercising original jurisdiction or conducting an appeal *de novo*. An additional problem in this particular case is that new source material in the form of hospital and treating notes relied on by Professor Large was not before the Tribunal. It is not in the interests of justice to admit the report on appeal.

Outline of material before the Court

[22] The Court has been provided with considered written submissions from each party as well as a 187-page bundle of relevant material drawn from the Tribunal file. The appellant has filed an affidavit from Ms Hannah Kate Quadrio sworn on 14 September 2018, annexed to which is a copy of the transcript from the Tribunal hearing on 4 June 2018 ("the transcript"). The Tribunal's reasons are contained at pages 19-20 of the transcript. I will not summarise all the material before the Tribunal at the time of the decision on 4 June 2018, however, some history is required to properly examine the Tribunal's reasons and the submissions made on appeal.

[23] The appellant is a 47-year-old woman with a diagnosis of schizoaffective disorder.[21] The appellant resides in Darwin with her carer. The fact the appellant has a mental illness within the meaning of s 6 of the *MHRSA* is not in dispute. The fact that the appellant requires care and treatment is similarly uncontentious. Prior to the hearing, the appellant was receiving an intramuscular injection of Olanzapine pamoate (405mg) every two weeks. She had also been prescribed with lithium carbonate (1350mg daily) which she was taking orally three times per day.

[24] The appellant was in hospital for most of the latter half of 2016. In June 2017, a CMO application was made but was denied by the Tribunal. On 7 November 2017 the appellant was admitted to hospital and was released the day later on an 'interim CMO'.[22] On 23 November 2017 she was

21 Parties' agreed bundle of relevant material at 3.

22 Parties' agreed bundle of relevant material at 5.

readmitted to hospital for just over one month. On 27 December 2017 the appellant was discharged from hospital on a CMO. She was admitted to hospital again in March 2017 for a period of two weeks.

[25] On 14 May 2018 Dr Willcocks, the appellant's treating psychiatrist, prepared a Form 15.[23] In that document, Dr Willcocks summarised the appellant's clinical history and expressed the opinion that each of the criteria for involuntary treatment in the community set out in s 16 of the Act were met. Dr Willcocks observed that the appellant was not capable of giving informed consent to treatment or had unreasonably refused to consent to treatment[24] for the reason that '[AX] continues to attribute her symptoms to "nervous breakdowns" and has poor insight evidenced by nonadherence to medications.'[25]

[26] In the same Form 15, Dr Willcocks noted the appellant 'showed no signs of mental state deterioration' but the appellant had indicated she thought her lithium dose was too high, and had requested a dose reduction. Dr Willcocks also recorded that the appellant believed her previous mental state deteriorations were all due to stress.

[27] On 4 June 2018 the Tribunal comprised of the legal member, the medical member and the community member. Dr Willcocks was also in

23 Parties' agreed bundle of relevant material at 3-6.

24 Parties' agreed bundle of relevant material at 4.

25 Parties' agreed bundle of relevant material at 4.

attendance. The appellant was present and was represented by Ms Hannah Quadrio from the Northern Territory Legal Aid Commission.

[28] At the hearing, Dr Willcocks described the appellant as having been 'relatively stable'[26] over the previous six months and 'doing quite well'.[27] Notwithstanding the appellant's progress, Dr Willcocks requested that the appellant be placed on a further CMO. She stated:[28]

> We know that [AX] has a tendency to ask for medication reductions and changes and she gets quite concerned about side-effects and, I guess, prioritises them above mental state at times, and I think the risks when she's unwell are quite high. I think for those reasons that it would be good to continue…under a CMO.

[29] Ms Quadrio led evidence from the appellant and Dr Willcocks at the hearing. The appellant objected to a new CMO. The relevant passage from the transcript reads as follows:[29]

> HQ: So, [AX], do you think you have a mental illness?
>
> AX: Yes.
>
> HQ: And what is it, does it have a name?
>
> AX: Schizo-affective bipolar.
>
> HQ: And do you think you need medication for that illness?
>
> AX: Yes.
>
> HQ: What happens if you don't have medication for it?
>
> AX: I'll be sick.

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26 Transcript of Tribunal Hearing, 4 June 2018 at 3 (lines 87-88).

27 Transcript of Tribunal Hearing, 4 June 2018 at 4 (line 92).

28 Transcript of Tribunal Hearing, 4 June 2018 at 4 (lines 94-99).

29 Transcript of Tribunal Hearing, 4 June 2018 at 5-7 (lines 119-160).

[…]

HQ: And how do you remember to take the tablets?

AX: I set my alarm on the phone.

HQ: You set your alarm, okay. And do you think the medication helps you?

AX: Yes.

HQ: How does it help you?

AX: It makes me feel better, think better, do things a bit better, and functions a bit better.

HQ: That's good. Do you have any concerns about your medication?

AX: Um, at the moment, just a bit too much I think, it's just that I get a lot of pains and sickness and all of that.

HQ: Yeah.

AX: So, but I'm putting up with it.

HQ: Yeah, and I understand you've been talking to Dr Willcocks about that?

AX: Yes.

HQ: And working with her on how to manage some of those side effects?

AX: Yes, we are.

HQ: Yeah, that's good. Are you happy to continue doing that, taking the medication and talking to Dr Willcocks?

AX: Yes. Yes.

HQ: How do you feel about being on the CMO?

AX: I just feel like something hanging on me and like, I'm what do you call it, [on] house arrest, you know. Like I have to behave or something like that, you know. It just changed my thinking. It's like I'm in prison but at home. Something is there that I have to do this, I have to, I have to, I have to you know, which I know how to do it already, so.

HQ: Would you keep taking the medication if you were not on a CMO?

AX: Yes.

[30] At a later stage in the hearing, Ms Quadrio asked Dr Willcocks whether she considered the appellant had the capacity to consent. Dr Willcocks said:[30]

> At the moment, yes. I think when she becomes unwell, no. But obviously capacity is dependent on, you know, time and the actual question before you.

[31] Dr Willcocks was also asked about the length of time the appellant had been compliant with medication. The relevant passage from the transcript reads:[31]

HQ: There are a few comments in the report which suggest non-compliance, but from my discussions with [AX], it seems like she has been compliant for quite a number of months, if not more.

BW: So, we know that when [AX] has come into hospital unwell, we know that generally she has told us that she's not been fully compliant. I think generally when she's well, she's compliant. I wonder if something, you know, makes you start becoming unwell and then the change in thinking is what then leads to some non-compliance.

AX: (…all that)

BW: Yeah. I don't think you deliberately go off it, you know, all the time. I think, at some points, you've had some concerns about medication side-effects and then have decided that maybe a

30 Transcript of Tribunal Hearing, 4 June 2018 at 13 (lines 325-326).

31 Transcript of Tribunal Hearing, 4 June 2018 at 14 (lines 328-347).

medication is not very good for you. And, you know, sometimes you come in and then you tell us that you want to go off them, but I think sometimes also that you might just decide if it's a tablet, it's easier to not take it. And I think that's what happened with your Sodium valproate at one point.

HQ: And when abouts was that?

BW: Ah, I don't recall. Possibly 2014, maybe 2016.

AS: That was…

BW: Maybe 2014.

[32] Ms Quadrio then made final submissions, after which the Tribunal adjourned to consider its decision. The Tribunal returned and announced its decision to make the CMO as follows:[32]

> [AX], we have listened very carefully to what you told us […] we've also listened to your doctor and we have heard the very important submission made by your lawyer. But right now we're not accepting that you have the sort of insight that is necessary that would give us the confidence not to make a CMO today. We certainly believe that you have a degree of insight, but we think that at times that changes. That's normal, alright. That does happen. But because of that, we are satisfied as we must be, that you have a mental illness, because you've agreed with that, that as a result of that you do require treatment, that without that you're likely to suffer a serious mental or physical deterioration. We've based that on the past and not the distant past; it's recent; and that right now you are not capable of giving the informed consent that is required. There are times where we think you've reached it, but there are times very recently where it hasn't as well. It fluctuates. But it's not so far, your refusals, your lack of insight is not so long ago, that we accept what your lawyer has said, alright; she's made some very important submissions but we don't accept that. And that the treatment is able to be provided by a Community Management Plan that has been prepared and is capable of being implemented. So we are going to make an Order today for

32 Transcript of Tribunal Hearing, 4 June 2018 at 19 (lines 466-486).

six months. We'll have you come back on 19th November 2018 and we do hope that things go as well as you obviously are intending that they go, and then we'll look at it again, alright. We promise we will listen, just like we did today.

Ground I: the evidence was not capable of supporting a finding that the appellant was incapable of giving informed consent and/or that the Tribunal failed to apply any standard of proof.[33]

[33] In reviewing a CMO and deciding whether a person has capacity to give informed consent to medical care or treatment, the relevant standard of proof is as articulated in *Briginshaw v Briginshaw* ("*Briginshaw*").[34] That standard provides that if a positive finding in respect of a person would produce grave or adverse consequences, the evidence to support such a finding should be clear, compelling and of high probative value.[35] A decision-maker cannot be satisfied of a fact in issue where that fact is based on 'inexact proofs, indefinite testimony or indirect inferences'.[36]

[34] It has been submitted that there was insufficient evidence before the Tribunal to support the conclusion that the appellant could not provide informed consent to medical care and treatment, and as a result, the Tribunal's finding of fact was not made to the *Briginshaw* standard. Further, it was argued that even if it were open to the Tribunal to make a finding that the appellant lacked capacity to consent to medical care and treatment, the Tribunal's reasons did not evince an appreciation of the

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33 Ground I is expressed in these terms in the Appellant's written submissions of 14 September 2018 at [8].

34 [1938] HCA 34; 60 CLR 336.

35 *JXC v Mental Health Review Tribunal & Anor* [2018] NTSC 62 at [30].

36 *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362.

need to apply the *Briginshaw* test to such an important question, and as a result, their decision was made in error. The appellant provided a number of reasons in support of this ground of appeal, which are briefly summarised below.

[35] Firstly, the appellant submitted that in the context of Dr Willcocks' evidence at the hearing that the appellant could provide informed consent, there was not a sufficient basis for the Tribunal to find, to the *Briginshaw* standard, that the appellant could not provide such consent. Dr Willcocks explained at the hearing that the appellant had 'previous times where she's felt concerned that she was getting side-effects and so therefore has stopped medication regimes'[37] but also observed that the appellant had been 'relatively stable' over the previous six months.[38] As outlined above, when asked directly at the hearing whether Dr Willcocks considered the appellant had the ability to consent, Dr Willcocks stated as follows:[39]

> At the moment, yes. I think when she becomes unwell, no. But obviously capacity is dependent on, you know, time and the actual question before you.

[36] Counsel for the appellant conceded that in determining whether a person is capable of giving informed consent, a decision-maker is not limited by whether the person expressed informed consent on the particular day the decision is made. However, it was submitted that capacity can change

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37 Transcript of Tribunal Hearing, 4 June 2018 at 14 (lines 83-85).

38 Transcript of Tribunal Hearing, 4 June 2018 at 3 (line 88).

39 Transcript of Tribunal Hearing, 4 June 2018 at 13 (line 325).

over time[40] and undue reliance on the past could result in unfairness, because 'it robs [a person] of their capacity to show that they have changed or that given, say a change to their medication regime, their ability to consent has improved'.[41] In support of that submission, the appellant referred to the decision of the Victorian Mental Health Tribunal in *XWZ*,[42] where weight was given to the presentation of the person at hearing.[43] The decision in that matter differs somewhat from the present proceeding in that it related to the question of whether a person could provide informed consent to electroconvulsive treatment (ECT). Some caution also needs to be applied with cases involving interstate legislation. Nevertheless, it is instructive to consider the approach taken. The Tribunal held:[44]

> …the majority was satisfied that XWZ was able to articulate a clear and rational basis for his opposition to this form of treatment and his preference to persevere with medication […] [A] person's capacity to give informed consent changes over time. The majority felt that XWZ's level of capacity demonstrated at the time of the hearing was markedly improved compared with the preceding several days and that some of the observations set out in the Report…were not reflected in his mental state during the hearing.

[37] Secondly, the appellant submits that where there is prima facie evidence of the ability to provide informed consent at the time of a hearing, there

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40 The appellant observed that s 68(2)(b) of the *Mental Health Act* 2014 (Vic) expressly recognises that capacity may change over time: see Appellant's written submissions of 14 September 2018 at [21].

41 Appellant's written submissions of 14 September 2018 at [21].

42 [2016] VMHT 25.

43 Appellant's written submissions of 14 September 2018 at [22].

44 XWZ [2016] VMHT 25.

ought to be a cogent basis for finding that the person is not able to give that informed consent. The appellant submits that the evidence before the Tribunal did not provide a cogent basis for their decision in the context of Dr Willcocks' evidence.[45] Reliance was placed on the appellant's oral testimony at the hearing, where she explained that she had a mental illness (which she named), that she needed to take medication (which she also named), that the medication helped her (and how), and that she intended to keep taking it even if she was not on a CMO. Emphasis was also placed on the appellant's explanation that her hospital admission in March 2017 was in part due to her taking St John's Wort, a herbal remedy which had interfered with the prescribed medication that she was still taking at that time and had continued to take, and not due to non-compliance.[46]

[38] The appellant's submissions also emphasised the lack of clarity and information on the extent of her non-compliance with her medication in the past. Particular reference was made to issues that arose at the hearing surrounding whether previous deteriorations in the appellant's mental state were due to non-compliance or to other factors, such as the dosage of medication prescribed[47] or that fact the appellant had been taking St John's Wort at the time of her March admission without Dr Willcocks'

45 Appellant's written submissions of 14 September 2018 at [27]-[30].

46 Appellant's written submissions of 14 September 2018 at [27].

47 Transcript of Tribunal Hearing, 4 June 2018 at 20-21 (lines 357-390).

knowledge. The appellant contends that the 'equivocal'[48] nature of the evidence regarding her non-compliance with medication means the Tribunal could not have been satisfied to the *Briginshaw* standard that she was unable to consent to medical care or treatment.

[39] Finally, the appellant refers to her explanation of the impact of the CMO on her life, and particularly her evidence at the hearing that she felt as though she was under house arrest when receiving compulsory treatment. Counsel for the appellant submitted that this 'powerful incentive' for the appellant to stay compliant with medication was 'dismissed by the Tribunal without consideration or recognition of its importance to the question of informed consent'.[49]

[40] It is accepted here that serious consequences flow to a person who has been found to lack the capacity to give informed consent to treatment. In this context a CMO means they will receive involuntary treatment in the community. The personal consequences lead to some reduction of personal autonomy and potentially the interference with rights, dignity, privacy and self-respect. The appellant's expressions as set out above describing how she feels about being subject to a CMO are illuminating. This is why courts and tribunals have stressed that relevant findings and conclusions that lead to orders of this type must not be made unless there is clear and compelling evidence that is of high probative value. Proof of

48 Appellant's written submissions of 14 September 2018 at [3].

49 Appellant's written submissions of 14 September 2018 at [28].

an important fact should not be produced by inexact proofs, indirect testimony or indirect inferences.[50]

[41] I am not persuaded the Tribunal fell into error on this point when all of the relevant material is considered. It is accepted the Tribunal appeared to rely quite heavily on the history of the appellant's treatment including previous orders. History is important and relevant in these cases, although over reliance on history may lead to unfairness. The oral evidence before the Tribunal was only part of the material relevant to the question of informed consent. Dr Willcocks' evidence before the Tribunal, much of which may be interpreted as favourable to the appellant's case, was focussed on the appellant's appearance on the day of the hearing. She did also observe the appellant to be 'relatively stable' in the past 6 months. However, her evidence needs to be considered against the material in the Form 15 which pointed to 'fluctuating insight, erratic adherence with medications and treatment plan, and the risks AX is exposed to while unwell'.[51] The Form 15 also noted 'AX's condition has demonstrated improvement with good adherence to treatment (as has been seen in previous years under the CMO), and deterioration with poor adherence. The risks to AX associated with an impairment in mental state warrants assertive treatment'.[52] Further, in relation to giving informed consent, the Form 15 states 'AX continues to attribute her symptoms to "nervous

50 *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362.

51 Parties' agreed bundle of relevant material at 3.

52 Parties' agreed bundle of relevant material at 4.

breakdowns" and has poor insight evidenced by non-adherence to medications.'[53] Dr Willcocks did not retract any of those statements on the Form 15, although it must be acknowledged she commented favourably on AX's position before the Tribunal on the day of the hearing.

[42] Once all of the material is considered, principally including the Form 15, in my view the second respondent's submission is correct to the effect that it was not incumbent upon the Tribunal to accept Dr Willcocks' oral evidence which was presented at the hearing. The Tribunal members sufficiently discharged their obligations to the appropriate standard because they did not simply accept what was put before them in oral testimony but challenged and questioned it, ultimately making a finding that was contrary to what Dr Willcocks had stated at the oral hearing. In this matter it is the case, as submitted by the second respondent, that the Tribunal's state of satisfaction was in fact informed by direct evidence (not by inferences or possibilities),[54] namely, the appellant's history of non-compliance with medication, documented in the Form 15 prepared in May 2018, and the records of her previous hospital admissions. In this matter there was evidence before the Tribunal to satisfy the criteria set out in s 16 of the *MHRSA* which justified a further CMO, particularly the documents before the Tribunal. This was not, in my view, a case of the Tribunal coming to a decision based on 'inexact proofs'.

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53 Parties' agreed bundle of relevant material at 4.

54 Second respondent's written submissions in reply of 28 September 2018 at [21].

[43] The second respondent submitted that simply because the appellant gave evidence does not mean the Tribunal were obliged to accept her testimony as cogent evidence of her capacity to provide informed consent. It was submitted the appellant's evidence revealed 'at best, a perfunctory understanding of her illness, the proposed treatment, why that treatment was considered most appropriate for her, and what the likely outcome would be for her if she did not participate in the proposed treatment plan'.[55] While the quality of the appellant's insight is difficult to gauge, the Tribunal was not obliged to accept her evidence on that point.

[44] I agree the Tribunal was required to make findings in accordance with *Briginshaw* to determine whether the appellant was capable of giving informed consent to medical care and treatment, however in my view, the oral evidence which was supportive of the appellant's case at the hearing was somewhat tentative when seen against the background of evidence of fluctuating compliance with medication with serious detrimental consequences when the appellant became unwell as a result of non-compliance or for other reason. Clearly there was evidence in the Form 15 which strongly supported the Tribunal's decision. I would not uphold this ground.

Ground II: Denial of procedural fairness

55 Second respondent's written submissions in reply of 28 September 2018 at [8].

[45] The second ground of appeal is that the decision of the Tribunal was affected by error because the appellant was denied procedural fairness. The basis for that contention is that the Tribunal failed to provide the appellant and/or her legal representatives with adverse information from its file upon which it relied when coming to its conclusion. When examining the material before the Tribunal, it is reasonable on one view to conclude that on the day of the hearing, it may have appeared the appellant's case was going reasonably well for her in terms of demonstrating her understanding of the need for compliance with her medical regime. This was however specific to the day of and around the hearing. The appellant was able to answer questions directed to her and Dr Willcocks' oral evidence was quite favourable.

[46] However, Dr Willcocks still supported the CMO being made. There was adverse comment contained in the Form 15. There were references in the Form 15 to previous admissions for treatment and later CMOs. Both Dr Willcocks and the appellant referred to previous non-compliance with medication between 2014 and 2016.[56] During the course of submissions made by Ms Quadrio against imposing a CMO on the appellant, the legal member indicated Dr Willcocks' comments were based on what had occurred in the past and on strong evidence from what had occurred in the 'very recent' past.[57] The following exchange took place:[58]

56 Transcript of Tribunal Hearing, 4 June 2018 at 19 (lines 337-352).

57 Transcript of Tribunal Hearing, 4 June 2018 at 14 (lines 419-430).

HQ: So in [AX]'s case, we concede that she has a mental illness and that she needs treatment or care for that mental illness in order to keep her well. What I would like to focus on is the criterion in section 16(b)(3), which is around [AX]'s capacity to give consent to the treatment. So my submission is that criterion should be interpreted as a point in time test, rather than as a longitudinal test involving speculation about what will happen in the future. That is consistent with the ordinary meaning of the provision. It's also consistent with the principle in *Briginshaw* that, where a particular finding would have a grave affect on a person, the evidence supporting that finding must be clear, compelling, highly probative and not speculative. And to interpret that criterion as a point in time test is also consistent with the guidance in section 8 of the Act, specifically section 8 (a), (b) and (c) which speak of the need to interpret the Act so that a person receives treatment in the least restrictive environment; and so that any interference is kept to the minimum necessary and the autonomy of the person is preserved and enhanced. Now, [AX]'s feeling is that her autonomy and her independence is not enhanced by a CMO and that she would prefer the less restrictive option of taking her medication without the compulsive backing of a CMO. And I would say that when section 16(b)(3) is interpreted as a point in time test, [AX]'s particular case doesn't meet that test because at the moment, [AX] does have capacity to consent, and for the last period of months, perhaps more, [AX] has been consenting to medication, at least at a broad level, and that the evidence that we have about non-compliance is fairly uncertain and speculative.

JT: Based on what's happened in the past.

HQ: Yes. That's certainly how I understood Dr Willcocks comments that there is some speculation about the reasons for admission.

JT: Based on strong evidence from what has occurred in the past, you would have to acknowledge that.

HQ: No

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58 Transcript of Tribunal Hearing, 4 June 2018 at 16-17 (lines 394-430).

JT: It's misleading to refer to it as speculative, given the very, very recent admissions. That's a …That's not speculative. The doctor has said that obviously she's. Nothing can be certain in this world, let's face it. But when statements are made by the doctor in relation to concerns about compliance, they're obviously based, significantly, I mean we wouldn't need the doctor to say in word for word, but significantly, on what has happened in the very, very recent past. That's not speculative.

[47] In response to the appellant's arguments on ground two, the second respondent submitted that the principle of procedural fairness should not apply to specialist tribunals, such as the Mental Health Review Tribunal, in the same way it applies to courts. On this point, the second respondent pointed out that tribunals may act upon their own knowledge. [59] The second respondent argued that the Tribunal members afforded the appellant procedural fairness by doing the following:[60]

- They gathered all the relevant parties in the room and identify that they are there to review the doctor's decision to place the appellant on a CMO;
- They afforded the appellant's lawyer the opportunity to ask questions and explain that the Tribunal may have questions of their own;
- Throughout the hearing, every person 'gets heard'. The Tribunal went about the process of assessing the written report through asking questions and examining the evidence given at the hearing.

59 Second respondent's written submissions in reply of 28 September 2018 at 8.

60 Transcript of Proceedings, *AX v The Queen* (Supreme Court of the Northern Territory, LCA 39/2018, Justice Blokland, 5 October 2018) at 45.

[48] The second respondent also submitted that sufficient prior notice was provided to the appellant and her legal representatives about the information on the Tribunal file, specifically in relation to the issues of the appellant's non-compliance with medication.[61] On 23 June 2018 the appellant was provided with a client history document[62] that revealed the appellant had 29 previous presentations before the Tribunal. The second respondent submits that as a result of the provision of that document, the appellant and her representative had prior notice that the Tribunal was in possession of historical material, so there was no procedural unfairness.[63] Further, the appellant made no application to examine those documents or seek an adjournment.[64] The list of historical orders and admissions concerning the appellant recorded dates, appearances and the type of order, with little other information. However, together with the Form 15, in my view it was reasonable to proceed on the understanding that recent orders and admissions in the context of a lengthy history of the same would be before the Tribunal. Even given the constrained circumstances that duty lawyers operate in before the Tribunal, it seems reasonable disclosure of the substance of any adverse material took place.

[49] Ms Quadrio explained in her affidavit that the civil section of the Northern Territory Legal Aid Commission (NTLAC) provides a duty

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61 Second respondent's written submissions in reply of 28 September 2018.

62 See Affidavit of Hannah Kate Quadrio sworn 14 September 2018, Annexure HKQ-2.

63 Second respondent's written submissions in reply of 28 September 2018 at 10.

64 Second respondent's written submissions in reply of 28 September 2018 at 11.

lawyer's service to persons appearing before the Tribunal.[65] The duty lawyer service has been provided to such persons since early 2016. If NTLAC have acted for a client previously, and if time permits, there may be a review of historical materials, over and above the usual duty lawyer service that by necessity is confined to reviewing the recent application before the Tribunal, taking instructions and if time permits, reviewing any previous dealings with the client in order to familiarise themselves with the past instructions and proceedings. It is reasonable to infer that given the pressures of time and the nature of the duty lawyer service, there is not often an opportunity to review in any depth historical materials or to take detailed instructions before the day of the Tribunal hearing. It is not usually the case that there is time or opportunity to prepare written submissions on behalf of a patient or to provide independent evidence.[66] All of that is understandable. This is not the fault of either party. It is a natural consequence of expedited summary hearings, which are positive features of how the Tribunal exercises its jurisdiction. Additionally, lawyers acting as part of a duty lawyer service are providing representation in difficult or constrained professional circumstances. The question of whether the appellant was denied procedural fairness must also be seen in this overall context.

65 Affidavit of Hannah Kate Quadrio sworn 14 September 2018 at 1.

66 Affidavit of Hannah Kate Quadrio sworn 14 September 2018 at 2 [4].

[50] While I agree with the second respondent's submission that procedural fairness in the context of this Tribunal cannot be assimilated to the standard expected in a court, if there are matters of substance that will weigh in a significant way against a party, it is accepted fairness dictates there needs to be some indication to a person or their representative who is the subject of proceedings that submissions or evidence is to be disregarded, or that other adverse material is likely to inform the final decision. For therapeutic reasons, bringing these matters to the attention of a patient or their representative would understandably not be done in any manner resembling a confrontational or adversarial process or remotely approaching how a court might deal with material adverse to a party's interests. Procedural fairness is highly context specific and the nature of the Tribunal must be considered. Although I agree with the appellant's argument to the extent that procedural fairness has not been excluded from the operation of the Tribunal, in my view the substance of relevant adverse material was brought to the appellant's attention. It is not apparent that the Tribunal sourced material beyond what was discussed at the hearing or referred to in the documents disclosed to the appellant.

[51] Although in the context of an Independent Merits Review under the *Migration Act* 1958 (Cth) concerning a refugee status assessment, in *Minister for Immigration and Border Protection v WZARH* ('*WZARH*'),[67]

67 [2015] HCA 40; 256 CLR 326.

Kiefel, Bell and Keane JJ said of determining the content of procedural fairness:[68]

> It is sufficient to say that, in the absence of a clear, contrary legislative intention, administrative decision makers must accord procedural fairness to those affected by their decisions. Recourse to the notion of legitimate expectation is both unnecessary and unhelpful. Indeed, reference to the concept of legitimate expectation may well distract from the real question; namely what is required in order to ensure that the decision is made fairly in the circumstances having regard to the legal framework within which the decision is to be made.

[52] Their Honours went on to approve what was said in *SZBEL v The Minister for Immigration and Multicultural and Indigenous Affairs*;[69]

> "It is… not to the point to ask whether the [decision-maker's] factual conclusions were right. The relevant question is about the [decision-maker's] processors, not its actual decision."

[53] Further, given the context of *WZARH*, their Honours referred to how in that instance a second reviewer '*might*' have made a difference to the outcome of that particular process. In formulating what may be required in that context, Gageler and Gordon JJ said:[70]

> That requirement necessitates at least that the opportunity to be heard that is given to an offshore entry person in each process is an opportunity which a reasonable assessor or reviewer ought fairly to give in the totality of the circumstances. That standard for compliance derives from the fundamental obligation of the Minister

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68 *Minister for Immigration and Border Protection v WZARH* [2015] HCA 40; 256 CLR 326 at [30].

69 *Minister for Immigration and Border Protection v WZARH* [2015] HCA 40; 256 CLR at [42] citing *SZBEL v Minister for Immigration and Multicultural and Indigenous Affairs* [2006] HCA 63; 228 CLR 152 at 160 [25].

70 *Minister for Immigration and Border Protection v WZARH* [2015] HCA 40; 256 CLR 326 at [53].

> to afford procedural fairness, which conditions the Minister's exercise of the statutory power which the processes inform. To satisfy the condition of procedural fairness, the Minister is obliged to adopt 'a procedure which conforms to the procedure which are reasonable and fair repository of the power would adopt in the circumstances'.[71]

[54] Their Honours further reasoned as follows:[72]

> The concern of procedural fairness, which here operates as a condition of the exercise of the statutory power is with procedures than with outcomes. It follows that a failure on the part of an assessor or reviewer to give the opportunity to be heard which a reasonable assessor or reviewer ought fairly to give in the totality of the circumstances constitutes, without more, a denial of procedural fairness in breach of the implied condition which governs the exercise of the Minister's statutory powers of consideration.
>
> Such a breach of the implied condition which governs the exercise of the Minister's statutory powers of consideration is material so as to justify the grant of declaratory relief by a court of competent jurisdiction, if it operates to deprive the offshore entry of the person of "the possibility of a successful outcome".[73]

[55] The following was added:[74]

> Contrary to the submission of the Minister in this appeal and has repeatedly been recognised in the Full Court of the Federal Court, Lam is not authority for the proposition that it is incumbent on the person who seeks to establish denial of procedural fairness always to demonstrate what would have occurred if procedural fairness has had been observed. What must be shown by persons seeking to establish a

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71 *Minister for Immigration and Border Protection v WZARH* [2015] HCA 40; 256 CLR 326 at [53] citing *Kioa v West* [1985] HCA 81; 159 CLR 550 at 672.

72 *Minister for Immigration and Border Protection v WZARH* [2015] HCA 40; 296 CLR 326 at [55]-[56].

73 Citing *Stead v State Government Insurance Commission* [1986] HCA 54; 161 CLR 141 at 147; *Re Refugee Review Tribunal*; *Ex parte Aala* [2000] HCA 57; 204 CLR 82 at 116-117 [80]-[81], [122] and [104].

74 *Minister for Immigration and Border Protection v WZARH* [2015] HCA 40; 256 CLR 326 at [58]-[59].

> denial of procedural fairness will depend upon the precise defect alleged to have occurred in the decision-making.
>
> There are cases in which the conduct on the part of an administrator in the course of a hearing can be demonstrated to have misled a person into refraining from taking up an opportunity to be heard that was available to that person in accordance with an applicable procedure which was otherwise fair. To demonstrate that the person would have taken some step if that conduct had not occurred is, in such a case, part of establishing that the person has in fact been denied a reasonable opportunity to be heard.

[56] As indicated, procedural fairness is not excluded by any clear statutory provision or necessary interpretation of the *MHRSA*, however, the particular context must be firmly kept in mind. It is clear from the recent authorities cited above that simply because a person claiming a breach of procedural fairness cannot show there has been practical injustice does not mean a claim to a breach of procedural fairness should fail. After reviewing the material before this Court, although it may be that the Tribunal's reasons could have been clearer about the material relied on, I am not persuaded that in the circumstances procedural fairness was denied. Generally speaking it is sufficient to inform an opposing party of the substance of the case to be answered.[75] Sufficient adverse material and comment during the hearing was available to put the appellant on notice that adverse historical matters, particularly those mentioned in the Form 15 would be relied on. There was appropriate notice given of issues of non-compliance, both historical matters and more recent examples.

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75 *Minister for Immigration Local Government and Ethnic Affairs v Kurtovic* (1990) 21 FCR 193 at 197, 205, 223.

[57] The papers forwarded by the Tribunal to NTLAC on 29 May 2018, prior to the hearing on 4 June 2018, are annexed to the affidavit of Ms Quadrio.[76] They include the Form 15 and the client Tribunal history, which gives one line references to dates and orders made back to 2009. Since the hearing on 4 June 2018, Ms Quadrio stated that when she reviewed the Tribunal file, she observed that while there was some overlap, the Tribunal file contained far more historical material relating to the appellant, much of it predating the NTLAC involvement in the duty lawyer service and other references to more recent Tribunal hearings at which the appellant was not represented by NTLAC. This included material from November 2017 when the appellant was unrepresented as NTLAC were unable to obtain instructions as well as material relating to the hearing on 27 December 2017 when the appellant was represented by private lawyer. The Tribunal's file consisted primarily of the written material that supports applications for involuntary treatment, but not the medical records prepared for such a purpose. It did not contain transcripts of the Tribunal hearings from the past or otherwise record submissions and representations including questions asked of the appellant's treating team or whether there had been any qualifications or corrections in oral hearings to the written material. Nevertheless, clearly the appellant had prior notice the Tribunal was in possession of historical material. The

76 Affidavit of Hannah Kate Quadrio sworn 14 September 2018, Annexure HKQ-2.

state of the appellant's file does not materially assist the procedural fairness claim.

[58] Ms Quadrio states that had she known the content of the appellant's file before the Tribunal, she would have made submissions about the nature of that material. For example, that it primarily presented the perspective of the treating team from various years without capturing any of the oral submissions made on behalf of the appellant at hearings. She would have submitted that the Tribunal be cautious about treating the file as uncontested evidence of the appellant's history without knowing which of the statements and reports in the file were contested, qualified or otherwise corrected in the hearings. She would have submitted it would be unfair and potentially prejudicial for the Tribunal to rely on that material, particularly historical material, as though it was uncontested evidence. Ms Quadrio states she would have sought instructions to obtain audio recordings, in order to inform the Tribunal of what historical matters had been contested and in particular when assertions of non-compliance had been contested. The substance of what the Tribunal would rely on however, must have been evident before the hearing.

[59] While it is difficult to ascertain from the reasons precisely what other material from the appellant's file if any the Tribunal relied on aside from the Form 15 and the oral evidence, it is reasonable to infer that the Form 15 was influential in the reasoning process. Without underestimating the difficulties for duty lawyers appearing before the

Tribunal or officers of the Tribunal it seems in some cases it would be useful if arrangements could be made for summaries of previous proceedings to be available, however in this matter, I am not persuaded this ground is made out.

Ground III: the Tribunal failed to take into account section 8 of the *MHRSA* when conducting the review

[60] The final ground of appeal is that the Tribunal erred by failing to take into account the principles in s 8 of the *MHRSA* when reviewing the CMO, specifically, that treatment is the 'least restrictive' and undertaken in the 'least intrusive' environment[77] and that any interference with 'rights, dignity, privacy and self-respect' be kept to a minimum.[78]

[61] Counsel for the appellant submitted that the appellant's dignity and self-respect were not considered by the Tribunal in the course of their decision-making. Reference was made to the following testimony from the appellant at hearing:

> I just feel like something hanging on me and like, I'm what you call it, [on] house arrest, you know. Like I have to behave or something like that, you know. It just changed my thinking. It's like I'm in prison but at home. Something is there and I have to do this. I have to, I have to, I have to you know, which I know how to do it already, so.[79]

[62] In response to the appellant's concern, a Tribunal member later stated 'believe me, it's not like that. It may feel like it, but it's not like house

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77 *Mental Health and Related Services Act* (NT), s 8(a).

78 *Mental Health and Related Services Act* (NT), s 8(b).

79 Transcript of Tribunal Hearing, 4 June 2018 at 6 (lines 154-158).

arrest'.[80] The member went on to say to the appellant, 'so really, what they're asking is every two weeks for an injection and, what is it, a monthly review'.[81] The appellant submitted that the Tribunal dismissed the appellant's concerns, despite the fact those concerns related directly to her dignity, privacy and self-respect. It was argued as a result, the Tribunal failed to exercise its power in a way that reflected the principles in s 8. I am not persuaded the cited interaction between the appellant and Tribunal members represents a dismissal of the appellant's concerns.

[63] The purpose of s 8 is to provide a series of checks and balances when enforcing various provisions within the *MHRSA*. Section 8 should be read in conjunction with s 3, which sets out the objects of the *MHRSA* as a whole. The *MHRSA* is to ensure the integrity of treatment and the rights of people with mental illness, but also, as submitted by counsel for the second respondent, it imposes a 'correlative duty' on the Tribunal to neutralise or reduce the likely risk of harm to persons who may become subject to the *MHRSA* in the context of their overall lives. It was submitted that this is a necessary consequence of the objects of the *MHRSA* being to provide for the care, treatment and protection of people with mental illness whilst at the same time protecting their civil rights.[82] I agree.

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80 Transcript of Tribunal Hearing, 4 June 2018 at 12 (line 229).

81 Transcript of Tribunal Hearing, 4 June 2018 at 12 (lines 301-302).

82 *Mental Health and Related Services Act* (NT) s 3(a).

[64] Given the Tribunal found the appellant did not have the capacity to consent to medical treatment or care, it is likely the Tribunal reasoned the CMO was the least restrictive option available in the circumstances. I would not uphold this ground.

[65] Section 143 of the *Mental Health and Related Services Act* provides:

> On hearing an appeal, the Supreme Court may make any of the following orders:
>
> (a) Affirm, vary or set aside the decision or order of the Tribunal;
>
> (b) Make any decision or order that the Tribunal may have made;
>
> (c) Remit the matter to the tribunal for further consideration;
>
> (d) Make any other order it thinks fit.

[66] The CMO made on 4 June 2018 will be affirmed in accordance with s 143(a) above.

[67] I note the Court has not been asked to exercise the powers under s 142(4) to suspend the operation of the current order being appealed, nor to refuse to hear the appeal under s 142(5) on the grounds *inter alia* that it had not been filed in good faith. Accordingly, the exercise of those powers has not been considered.

Orders

1. The appeal is dismissed.

2. The CMO made on 4 June 2018 is affirmed.

3. I will hear counsel on the question of costs.
