SUPREME COURT OF QUEENSLAND

CITATION:	*A-G (Qld) v Bosanquet & Ors* [2012] QCA 367
PARTIES:	**ATTORNEY-GENERAL OF QUEENSLAND** (appellant) **v** **DAVID ANDREW BOSANQUET** (first respondent) **DIRECTOR OF MENTAL HEALTH** (second respondent) **DIRECTOR OF PUBLIC PROSECUTIONS** (third respondent)
FILE NO/S:	Appeal No 223 of 2012 MHC No 45 of 2011
DIVISION:	Court of Appeal
PROCEEDING:	Appeal from the Mental Health Court
ORIGINATING COURT:	Mental Health Court at Brisbane
DELIVERED ON:	21 December 2012
DELIVERED AT:	Brisbane
HEARING DATE:	8 June 2012
JUDGES:	Margaret McMurdo P and Gotterson JA and Philippides J Separate reasons for judgment of each member of the Court, each concurring as to the orders made
ORDERS:	**1. The appeal is dismissed.** **2. The decision of the Mental Health Court that the respondent was of unsound mind at the time of all the alleged offences the subject of the references to the Mental Health Court is confirmed.**
CATCHWORDS:	MENTAL HEALTH – DECLARATION OR FINDING OF MENTAL ILLNESS OR INCAPACITY – where the Mental Health Court found that at the material time the first respondent was of unsound mind as defined in the schedule to the *Mental Health Act* 2000 (Qld) – whether the Mental Health Court erred in determining that the first respondent's mental illness deprived him of the capacity to control his actions – whether the Mental Health Court erred in determining that the first respondent's mental illness deprived him of the capacity to know he ought not do the act – whether the Mental Health Court misapplied the concept of deprivation of capacity – whether the Mental Health Court erred in making a finding that the first respondent's state of

mind did not result, to any extent, from intentional intoxication or stupefaction – whether a fact that is substantially material to the opinion of the expert witnesses was so in dispute that it was unsafe to make the decision

Mental Health Act 2000 (Qld), s 267, s 269, sch 2

Attorney-General of Queensland v Kamali (1999) 106 A Crim R 269; [1999] QCA 219, cited
Berg v Director of Public Prosecutions (Qld) [2012] QCA 91, considered
DAR v DPP (Qld) & Anor [2008] QCA 309, considered
R v Porter (1933) 55 CLR 182; [1933] HCA 1, cited
Re B (unreported, Mental Health Tribunal, Dowsett J, 3 November 1997), considered
Re Bosanquet (unpublished, Mental Health Court, Ann Lyons J, 12 December 2011), related
Re LIH [2002] QMHC 14, considered
Re SAM [2003] QMHC 3, considered
Re W (unreported, Mental Health Tribunal, Dowsett J, 14 October 1997), considered
Reid v DPP (Qld) & Anor [2008] QCA 123, considered
Stapleton v The Queen (1952) 86 CLR 358; [1952] HCA 56, cited

COUNSEL: B J Campbell, with A K Lossberg, for the appellant and the third respondent
S J Hamlyn-Harris, with J D Briggs, for the first respondent
No appearance for the second respondent

SOLICITORS: Director of Public Prosecutions (Queensland) for the appellant and the third respondent
Legal Aid Queensland for the first respondent
No appearance for the second respondent

[1] **MARGARET McMURDO P**: The respondent was charged with one count of stalking and two counts of arson. The matter was referred to the Mental Health Court which determined that at the time of the three alleged offences he was of unsound mind. The appellant has appealed against that finding. Philippides J has thoroughly set out the relevant facts, issues and law. Her Honour has concluded that the Mental Health Court's finding of unsoundness of mind, on the basis that the respondent's mental illness alone resulted in the deprivation of his capacity to know he ought not do the acts constituting the alleged offences, was correctly made. I agree with that conclusion and with her Honour's reasons for it. It follows that the appeal must be dismissed. I agree with the orders proposed.

[2] **GOTTERSON JA**: I agree with the orders proposed by Philippides J and with the reasons given by her Honour.

[3] **PHILIPPIDES J**: On 12 December 2011 the Mental Health Court ("MHC") determined references made to it concerning the state of mind of David Andrew Bosanquet ("the respondent") at the time of the commission of three alleged

offences (one count of unlawful stalking and two counts of arson).[1] The present appeal is brought by the Attorney-General against the finding made by the MHC that at the material time the respondent was of unsound mind as defined in the schedule to the *Mental Health Act* 2000 (Qld) ("*MHA*").

Grounds of appeal

[4] The Attorney-General appeals that decision on the following grounds:

1. The MHC erred in concluding that, at the time of the commission of the alleged offences, the respondent was deprived of the capacity to control his actions.
2. The MHC erred in concluding that, at the time of the commission of the alleged offences, the respondent was deprived of the capacity to know he ought not to do the relevant acts.
3. The MHC misconceived and/or misapplied relevant tests to be applied in determining whether a person has been deprived of relevant capacities.
4. The MHC erred in concluding that, at the time of the commission of the alleged offences, the respondent's intoxication did not play any role in the deprivation of any of the capacities.
5. The MHC, in coming to a conclusion that there was a deprivation of a capacity by the mental illness alone and that intoxication did not play a role, erred in failing to find that a dispute of fact within the meaning of s 269 of the *MHA* arose between the parties as to substantially material facts in issue that it would be unsafe to make a decision.

[5] On the hearing of the appeal, the appellant submitted that these grounds could be distilled into the following three grounds: [2]

- Firstly, that the MHC "misapplied the concept of a deprivation of a relevant capacity instead concentrating on the cause or driver of the criminal behaviour" and was therefore distracted from the proper exercise of identifying a deprivation of a capacity and how that arose.
- Secondly, that the MHC "erred in its analysis of what is meant by the capacity to know he ought not do the act by concentrating on an analysis of whether the respondent was reasoning rationally", and therefore was distracted from the proper task as required by the *MHA* of determining whether the respondent's mental illness deprived him of the capacity to know he ought not do the act.
- Thirdly, that the MHC misapplied s 269 of the *MHA*, which precludes the MHC from "making the finding that it did if there is a fact that is so in dispute that it would be unsafe to make the decision, that fact being substantially material to the opinion of the expert witnesses". In that regard, the MHC erred in making a finding as to the issue of intoxication.

[6] Should the appellant succeed in his appeal, he seeks an order that the respondent was not of unsound mind at the time of the alleged offences. Alternatively, a finding is sought that there are facts substantially material to the opinion of an expert witness so in dispute that it would be unsafe to make a decision under s 267 of the *MHA*, with consequential orders that the respondent is fit for trial and that the

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1 *Re Bosanquet* (unpublished, Mental Health Court, Ann Lyons J, 12 December 2011).

2 Appeal Transcript 1-4, 1-5.

proceedings continue according to law. In the further alternative, an order is sought that the proceedings be remitted to the MHC to proceed according to law.

The nature of an appeal from a decision of the MHC

[7] In *Berg v Director of Public Prosecutions (Qld)*,[3] this court proceeded on the basis that an appeal from a decision of the MHC on a reference to this court pursuant to ch 2 of Pt 8 of the *MHA* is by way of rehearing rather than an appeal in the strict sense. Dalton J (with whom McMurdo P and Chesterman JA agreed), considered that that approach accorded with the prevalent view, referring to the discussion in *McDermott v The Director of Mental Health; ex parte A-G (Qld)*[4]. However, the court did not have the benefit of full argument on the matter and did not have regard to *DAR v DPP (Qld) & Anor*.[5] In that case, the question of the nature of an appeal from the MHC was authoritatively determined by this court. Keane JA (with whose judgment Holmes and Fraser JJA concurred) held that an appeal to this court from the MHC's determination on a reference is an appeal in the strict sense and not an appeal by way of rehearing.[6] Both parties to this appeal accept that, because the appeal does not proceed by way of rehearing, it is necessary for an appeal to succeed to show that the MHC fell into an error of law or fact.

Legislative provisions

[8] Section 267 of the *MHA* requires the MHC to consider whether, at the time the alleged offences were committed, the respondent was of "unsound mind".

[9] "Unsound mind" is defined in the schedule to the Act as meaning:

> "… the state of mental disease or natural mental infirmity described in the Criminal Code, section 27, but does not include a state of mind resulting, to any extent, from intentional intoxication or stupefaction alone or in combination with some other agent at or about the time of the alleged offence."

[10] The definition of the term "unsound mind" in the *MHA* not only incorporates the definition in s 27 of the *Code,* but is also informed by the exclusion in s 28(2) relating to intentional intoxication or stupefaction from disorders of the mind covered by s 28(1) of the *Code*.

[11] Section 27 of the *Criminal Code* (Qld) 1899 provides:

> "**27 Insanity**
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> (1) A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission the person is in such a state of mental disease or natural mental infirmity as to deprive the person of capacity to understand what the person is doing, or of capacity to control the person's actions, or of capacity to know that the person ought not to do the act or make the omission.
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> (2) A person whose mind, at the time of the person's doing or omitting to do an act, is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit

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3 [2012] QCA 91.
4 [2007] QCA 51 at [3], [34], [74].
5 [2008] QCA 309.
6 At [7]-[29].

of subsection (1), is criminally responsible for the act or omission to the same extent as if the real state of things had been such as the person was induced by the delusions to believe to exist."

[12] Section 28 of the *Criminal Code* (Qld) 1899 provides:

"**28 Intoxication**

(1) The provisions of section 27 apply to the case of a person whose mind is disordered by intoxication or stupefaction caused without intention on his or her part by drugs or intoxicating liquor or by any other means.

(2) They do not apply to the case of a person who has, to any extent intentionally caused himself or herself to become intoxicated or stupefied, whether in order to afford excuse for the commission of an offence or not and whether his or her mind is disordered by the intoxication alone or in combination with some other agent."

[13] Section 267 of the *MHA* is subject to s 269, which precludes the MHC from making a decision under s 267 if the MHC is satisfied a fact that is substantially material to the opinion of an expert witness is so in dispute it would be unsafe to make a decision as to unsoundness of mind.

[14] It is to be borne in mind that no party bears the onus of proof of any matter (s 405(1)) and that, for present purposes, the standard of proof is on the balance of probabilities (s 405(2)).

Circumstances concerning the charges

[15] The MHC outlined the circumstances concerning the referred charges of stalking on 4 October 2010 and two counts of arson on 5 October 2010 as follows:

"[4] It is alleged that on 4 October 2010 Mr Bosanquet left a series of voicemail messages on the telephone of his ex partner which were hostile and aggressive. The complainant and the defendant had been in a relationship which was 'on and off' over the previous 21 years. They had recently begun seeing each other again and the defendant had resided in a caravan next door to the complainant's caravan at the Proserpine Caravan Park.

[5] The defendant however moved from the caravan park after the complainant once again ceased their relationship due to his aggressive and unstable behaviour. The voicemail messages to the complainant were all aggressive, abusive and threatening and were made between 3.56 pm and 10.52 pm. Those messages give rise to the count of unlawful stalking on the evening of 4 October 2010.

[6] On the following morning 5 October 2010 at about 5am Mr Bosanquet's ex partner's caravan at the tourist park was set on fire. Another fire was started whilst police were in attendance at about 6.30 am at an adjacent site occupied by a man the defendant believed had commenced a relationship with his ex partner.

> [7] Mr Bosanquet was observed at the Proserpine BP Service Station a short time prior to the fires starting at the caravan sites. It is clear that the voicemail messages indicated that the defendant believed his former partner was in a relationship with the other man."

[16] Prior to the events the subject of the references, the respondent was involved in a single vehicle accident on 3 October 2010 at about 1.00 am when he crashed his four-wheel drive on the Bruce Highway south of Bowen. He was taken to the Bowen Accident and Emergency department. Blood tests taken soon after revealed that he had consumed both alcohol and cannabis.[7] He was seen by medical officers,[8] but later that morning was discharged to home.[9] He was subsequently charged with driving under the influence of alcohol and cannabis and convicted and disqualified from driving for six months.[10]

[17] In addition to his four-wheel drive, which was unable to be driven as a result of the accident, the respondent had a Kia Rio vehicle. However, the car which he used to drive from Bowen to Proserpine on 5 October 2010 was a third vehicle, which was hired. On the way to Proserpine he stopped to purchase a container of petrol. After the second fire was lit, the respondent drove back to Bowen and returned the hire car.

[18] He was located later by police and placed in custody. He was making threats to kill himself and others. Because of concerns as to his mental state, he was admitted to the Bowen Hospital under an Emergency Examination Order. At about 3.45 pm on 5 October 2010, he was transferred to the Mackay Base Hospital. A urine sample taken at 9.35 am on 7 October 2010 tested positive for cannabis, as did a sample taken on his discharge from the Mackay Base Hospital on 29 October 2010.[11]

[19] When initially spoken to by the police the respondent denied responsibility for the fires.[12] Prior to his discharge from Mackay Base Hospital the respondent was interviewed by police, admitting that he had likely made the phone calls but denying responsibility for the fires and providing an alibi in terms of his vehicle being at his home.[13] He was interviewed again on 13 December 2010, when he made admissions regarding the fires.[14]

The decision at first instance

[20] The MHC found that at the relevant times the respondent was suffering from a state of mental disease; namely a manic phase of a bipolar disorder. There was no complaint about that finding, nor was it disputed that the respondent held a delusional belief that his former partner was having an affair with a resident at the Proserpine Caravan Park (the male complainant).

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7 AR 522: THC (active ingredient) reading was 0.007 mg/kg; AR 523: the blood alcohol level was 0.062 per cent.
8 AR 354.
9 AR 502.
10 AR 517, 520.
11 AR 509, 510.
12 AR 418.
13 AR 300, 308-314.
14 AR 326-328.

[21] The MHC found that the respondent was of unsound mind on the basis that he was deprived as a result of his mental illness of the capacity to control his actions and to know he ought not to do the acts constituting the alleged offences. The MHC also held that it was not satisfied that "intoxication in fact played any role" in the deprivation of those capacities. It is these findings that are the subject of challenge on the appeal.

Expert evidence before the MHC

[22] The MHC was provided with reports from Dr O'Sullivan prepared pursuant to s 238 of the *MHA* dated 28 January 2011 and 14 April 2011 and a clarifying email of 24 February 2011.[15] At the time of the hearing Dr O'Sullivan had been the respondent's treating psychiatrist for about 18 months. An update report on the respondent's condition dated 19 September 2011 was also provided by Dr Lien in the absence of the treating psychiatrist. Dr Grant was the only psychiatrist appointed by the MHC to provide a report as an independent expert. Dr Grant saw the respondent on 23 May 2011 for the purpose of providing his report dated 27 May 2011.

[23] Both Dr O'Sullivan and Dr Grant gave oral evidence when the matter came before the MHC on 26 September 2011 and 2 November 2011.

Dr O'Sullivan

[24] The MHC referred to Dr O'Sullivan's report of 4 April 2011[16] and to his oral evidence. The MHC noted at [8] that Dr O'Sullivan indicated that the respondent had his first episode of mania five years previously, when he had numerous grandiose business plans and ended up in the street with no clothes on, threatening others. He did not receive any treatment at the time but it was likely that that was the first episode of his bipolar illness. During the 2006 episode he got into significant trouble with police due to his concern that Australia was being invaded and his belief that there was a religious solution involving "the Messiah and the intervention of God". Hospital notes at the time referred to him being "disorganised" and the mental state assessment noted "acceleration of thoughts and a grandiosity and a paranoid psychosis consistent with a manic episode of bipolar disorder".

[25] The MHC noted at [9] that Dr O'Sullivan indicated that after his arrest on 5 October 2010 he was assessed at the Mental Health Unit at Mackay, where he was found to be loud and disinhibited, as well as irritable and elevated in mood. He spoke in an accelerated manner, his thoughts were disorganised and he showed no insight and poor judgment. He was treated for a bipolar illness, and it was also noted that he had a history of marijuana abuse. The MHC also observed at [10] that Dr O'Sullivan considered that the respondent's judgment and insight were seriously impaired on account of his illness and that he was psychotic with delusional beliefs. While they were not of the same nature as those previously experienced, they were certainly attached to his perception of the activities of his partner and were delusionally based. Dr O'Sullivan diagnosed paranoid psychosis associated with a recurrence of a manic episode of bipolar.

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15 AR 197-206.

16 The reference is clearly a reference to the second report of 14 April 2011.

[26] The MHC noted at [12] Dr O'Sullivan's evidence that around the time of the index offences there was an interruption of his normal sleep pattern and activities which was consistent with the onset of a manic episode prior to the index offences. He considered that there was little doubt the respondent was in a manic phase of a bipolar disorder, which was complicated by alcohol abuse, whereby he was misconstruing reality to the extent that he was clearly psychotic.

[27] As to whether the respondent was of unsound mind, the MHC referred at [10] to the following opinion concerning the respondent's volitional capacity (contained in his report):

> "Dr O'Sullivan considered that Mr Bosanquet was mentally ill throughout 2010 including the time he was alleged to have stalked his ex partner and set fire to the caravans. He considered that on the balance of probabilities Mr Bosanquet was deprived of the capacity to control his actions and that he was labouring under several paranoid delusions at the time. …"

[28] The MHC referred to Dr O'Sullivan's oral evidence concerning the respondent's cognitive capacity of knowing that he ought not do the act in question.[17] The MHC noted at [11]:

> "Dr O'Sullivan considered that at the time, his illness was governing his thinking to the extent that he was unable, with a moderate degree of sense and composure, to think rationally of the reasons which, to ordinary people, would make those offences right or wrong."[18]

[29] As to the issue of intoxication, the MHC summarised Dr O'Sullivan's evidence in the following terms:

> "[13] Mr Bosanquet told Dr O'Sullivan that [he] cannot independently recall whether he had been drinking or taking drugs. He told Dr O'Sullivan however that when he starts becoming unwell he tends, amongst other things, to drink alcohol and use marijuana. Dr O'Sullivan stated that 'and that's not an uncommon sign in people drifting into a manic state. They do self medicate, or they do start to consume alcohol.' In many respects Dr O'Sullivan considers that Mr Bosanquet uses substances in an attempt to treat his symptoms. Dr O'Sullivan stated that using alcohol or using cannabis is part of the illness and said 'I see this with lots of people who drift in a manic state, they – they – it is like fish to water, they have this overwhelming desire to drink alcohol. I don't know what the attraction is, but it is some form of self medication, but they do get into all sorts of mood altering substances and I think self medication is a component of it.'
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> [14] Dr O'Sullivan stated 'I think that his control, his volitional control over his drug and alcohol consumption when manic is pretty close to nothing.' Dr O'Sullivan viewed intoxicant usage as 'being part and parcel of his psychotic state.'

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17 That was the only cognitive capacity in issue, as the other cognitive capacity (to understand one's actions) did not arise for consideration.

18 AR 106.

[15] Dr O'Sullivan also indicated that it was not safe to rely on his self report about the amount that he was drinking or the marijuana he was using prior to the index offences as he was out of touch with reality. He also said that when he saw him he was showing quite a considerable amount of contrition and 'making all sorts of apologies, perhaps more than he ought, so in any case I thought his judgment about what he had been drinking couldn't be taken as gospel at all'. He agreed that his explanations about drinking were consistent with a man who had begun treatment after having had a very severe exacerbation of his mental illness.

[16] He also stated that Mr Bosanquet made that statement when he was proceeding into a depressive swing where 'self-recrimination and guilt are a component of the mental state'. Dr O'Sullivan also considered that Mr Bosanquet's belief that he must have been drinking could be an attempt to find an explanation for his irrational behaviour.

> 'I think he'd come well and truly down from the manic swing and he was somewhat depressed and self blaming and I didn't feel he was trying to make excuses. I felt he was trying to provide – he was giving reasons why he, you know, wasn't such a good chap at all.'"

[30] In respect of Dr O'Sullivan's evidence as to the issue of deprivation of capacity and the role of intoxication, the MHC referred at [17] to the following evidence given by Dr O'Sullivan:

> "My own view is that the illness itself was sufficient for him to behave in the manner that he did and that I have no knowledge of his alcohol consumption and it appeared to me that his behaviour was accountable for – by in terms of his being psychotic and manic with or without alcohol being involved."[19]

[31] The MHC additionally observed at [18]:

> "Dr O'Sullivan also noted that Mr Bosanquet's psychotic symptoms continued for three weeks after his admission to hospital and in the absence of intoxicants. He considered that the continuation of paranoid psychotic symptoms in the context of an ongoing manic illness only confirms the original diagnosis that this was a man who was quite mentally ill prior to and throughout the index offences and beyond the index offences for a period of some weeks. He stated that the fact that it took some weeks for his mood to stabilise and for the anti-psychotic medication to take effect is 'textbook typical'. In his view if all of his conduct were accountable just simply in terms of alcohol intoxication and marijuana effects then his symptomatology and his mental state would have settled rather promptly 'as soon as those substances were out of his system and metabolised in the first few days or maybe a week but certainly not three weeks.'"

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19 AR 12.

Dr Lien

[32] The MHC referred at [20] to Dr Lien's update report dated 19 September 2011, which indicated the respondent had been stable for over six months, was abstaining from using alcohol and illicit substances, compliant with medication and fit for trial. The report noted that the respondent had limited insight into his mental illness. He acknowledged being "pretty crook" at the time of the offences and that he "went off the rails … did things that I would not normally do or say" which he put down to having "drunk and smoked too much".

Dr Grant

[33] The MHC outlined aspects of Dr Grant's report of 27 May 2011 in the following terms:

> "[22] … In his report he indicated that Mr Bosanquet told him that about a week before the events he had been charged with driving his car under the influence of alcohol. He told him that the blood test revealed that he was intoxicated with both cannabis and alcohol at the time. Mr Bosanquet also told Dr Grant that he recalls making telephone calls to the complainant and that he had become convinced that she and a person called David Buchanan were having a relationship. He stated he had no recollection of the arson offences and the first he knew about them was when the police arrested him. Although he does not recall committing the offences he indicated that it was too coincidental for someone else to have set fire to the caravans in the context of the conflict between himself and his former partner.
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> [23] Dr Grant recounted that Mr Bosanquet stated that in the period leading up to the offences he had been consuming an excessive amount of alcohol and that because he is not a heavy drinker alcohol tends to affect him quite severely. He said that he was having a big binge at the time and one of those binges ended up with him having the accident in his car. Because he lost his licence as a result of the accident and because his car was also smashed up this was very stressful to him. Mr Bosanquet said that in addition to the alcohol intoxication he was a chronic user of marijuana and had smoked 20 cones a day for a period of 40 years. It would appear that he told Dr Grant he smoked strong hydroponic marijuana and would often use up to 40 cones some days.
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> [24] Dr Grant stated that Mr Bosanquet believes that under the stressors he was experiencing he would have been smoking heavily at the time. He states that the combination of marijuana and alcohol has never been a good thing for him and leads to problems.
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> [25] Dr Grant also noted that Mr Bosanquet had an episode of mental illness in 2006 which was subsequently diagnosed as mania. It would also appear that at that time he had also been using a lot of marijuana."

[34] As to Dr Grant's opinion concerning whether the respondent was of unsound mind at the relevant times, the MHC stated:

> "[26] Dr Grant considered that at the time of the alleged offences Mr Bosanquet was suffering from mental illness, namely the manic phase of a bipolar affective disorder with psychotic beliefs. He considered that the delusions of infidelity by his ex-wife were present as a symptom of the manic episode. However Dr Grant initially believed from Mr Bosanquet's self report that there was evidence that he was also consuming both alcohol and cannabis at the time. Dr Grant considered that Mr Bosanquet was probably deprived of the capacity to know that he ought not do the acts and of the capacity to control his actions but was uncertain about the impact of possible intoxicants at the time.
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> [27] Dr Grant indicated that he initially accepted Mr Bosanquet's accounts of his excessive use of alcohol and marijuana over some time before the offences and recorded that Mr Bosanquet himself attributed the offences to the effect of the alcohol and drugs.
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> [28] It is clear however that at the time of writing his report Dr Grant did not have any hospital notes or any witness statements. In his written report Dr Grant initially considered that this deprivation was brought about by a combination of his mental illness and intoxication. Whilst he initially stated that in his opinion the mental illness alone would not have deprived him of either of those capacities Dr Grant however ultimately concluded that there was insufficient, reliable and objective information about either cannabis or alcohol consumption to be satisfied that intoxication played a role in the deprivation of any capacity.[20]
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> [29] Dr Grant ultimately considered that Mr Bosanquet's account of consumption was probably exaggerated. Furthermore Dr Grant indicated that Mr Bosanquet's attribution some months after the offending to drug and alcohol use was common with mania and is associated with lack of insight into the extent of the illness.
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> [30] Dr Grant also referred to the measurements of blood pressure and pulse which were taken on admission to hospital and did not consider that they were consistent with alcohol withdrawal as rapid pulse, sweating and maybe some increased blood pressure would be expected. He considered that the readings were more consistent with manic symptoms than intoxication or withdrawal. He also agreed that the admission notes recorded that he was

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20 As explained below, this does not accurately record the final opinion expressed by Dr Grant concerning the deprivation of the capacity for control, which was that he was unable to exclude intoxication as a contributing factor and therefore did not support a finding of unsoundness of mind on that basis.

'Attempting to enter their bedrooms' and was 'Oppositional towards medication.' He agreed that he was given Lorazepam which is used for treatment of manic behaviour. Dr Grant agreed that his manic symptoms were ongoing at that point and his behavioural problems were evident.

[31] Dr Grant also indicated that sometimes marijuana intoxication and psychosis can take quite a while to settle but that the length of time in this case was in fact consistent with a manic illness. Dr Grant considered that he started to settle after 10 days to two weeks which is the usual length of time that the mood-stabilising medications take effect when mania is present.

[32] Dr Grant also agreed with Dr O'Sullivan that drug and alcohol use can rise when a person becomes unwell in an attempt to manage the symptoms. He said that one of the consequences of becoming manic would be to use more substances, and that would be not at all uncommon. 'As Dr O'Sullivan said, it can be a way of person trying to use – control their symptoms, get some sleep, drinking a lot of alcohol, maybe smoking more marijuana because they're awake more hours of the day and more disinhibited and so on. So that's not at all an uncommon aspect of someone being unwell.'

[33] Dr Grant also indicated to Counsel for Mr Bosanquet:

> 'if you need to consider capacities separately then I would say that the thing that was primarily depriving him of the capacity[21] would be his delusions regarding that man. So that he – he might be sense deprived of the capacity to [know] – or not do the act by the delusions, whereas alcohol might have been playing more of a role in capacity to deprive him of control.'

[34] Dr Grant also agreed that the evidence indicated that Mr Bosanquet had hired a car and that he was at the caravan park for some time. He noted that when he was seen 12 hours later [by] a senior medical officer, there was no indication of alcohol or any suggestion that he smelt of alcohol. Dr Grant agreed that the fact that he hired a vehicle, drove it there and stayed there without revealing his purpose for that length of time suggests that he wasn't grossly intoxicated.

[35] In response to a further question Dr Grant agreed that it is probable that at the time of the offences that Mr Bosanquet was deprived of the capacity to know that what he was doing was wrong by reason of his illness alone. He considered that on the balance of probabilities that it was the

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21 This evidence is at AR 56 and the reference to "the capacity" appears to be a reference to the relevant cognitive capacity as opposed to the volitional capacity referred to at the end of the quote.

illness that deprived him of that capacity. Dr Grant stated that notwithstanding that Mr Bosanquet might have known at the time of the arson offences that what he was doing was illegal, and perhaps even that others might not have approved of it, he still considered that he was deprived of the capacity to know that what he was doing was wrong as through the intensity of his illness, he held a strong personal belief driven by his illness that he had the right to do the acts."

Advice from the assisting psychiatrists

[35] The MHC summarised the advice provided by Dr Lawrence, one of the assisting psychiatrists, in the following terms:

"[37] Dr Lawrence noted that whilst there was no actual blood tests contained in the material there was a reference to some blood test results in the discharge summary which indicated a reading showing one plus (1+) of cannabis in his urine drug screen on admission and the same amount at discharge some considerable time later. Dr Lawrence stated that those readings do not support his self report that he had been consuming '30 to 40 cones or 20 to 30 cones a day of cannabis for weeks, days – days or weeks.' Dr Lawrence considered that if he had been consuming that amount she would have expected 'at least a three plus level of cannabis and since one assumes that he had none in hospital, that it should have conceivably gone down a little. And so my guess is that – my – my conclusion would be that the amounts that he claimed to be using were inflated.' Dr Lawrence considered that as his symptoms escalated and his alcohol and cannabis use may well have increased but that the accuracy of these claims must be seen as being very unreliable and inconsistent.

[38] Dr Lawrence's advice was that tests that are available are not in accord with the variably claimed quantities of marijuana and alcohol used by Mr Bosanquet. Furthermore her clinical opinion was that those results do not confirm the presence of significant quantities of either alcohol or cannabis sufficient to influence the elevated mental state with its delusional beliefs which had been present for a considerable number of months prior to the offending behaviour.

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[40] Dr Lawrence's advice was that Mr Bosanquet's manic symptoms appear to have commenced at least 12 months before the offending behaviour and that he had previously held psychotic beliefs that the Indonesians and others were planning to invade Australia. She also indicated that he developed delusional beliefs that his de facto wife was having an affair. He had become threatening to her such that she had separated from him as a result of fears for her safety.

[41] Dr Lawrence also noted that all of the evidence consistently indicated that he was very elevated in mood and was obviously increasingly erratic and, at times, agitated. Dr Lawrence stated that whilst the reports of the use of substances are inconsistent, the descriptions of his manic behaviour in both the police and the hospital records at the time were remarkably consistent.

[42] Dr Lawrence noted that in his oral evidence Dr Grant expressed the clear opinion that it was the mania itself which produced a delusional belief of the infidelity, which then motivated the actions of both the obscene phone calls and the arson offences some hours later. Dr Grant formed the opinion that the mania itself deprived Mr Bosanquet of the capacity to know that he ought not do the act and also to control his behaviour, thus providing an unsoundness defence.[22] Dr Lawrence also noted Dr Grant's view that Mr Bosanquet needed a forensic order.

[43] Dr Lawrence stated that the Court process in this case highlighted the initial absence of important pieces of clinical information. That information included the records of his hospital admissions around the time of the alleged offences. That information was subsequently provided and included notes from Bowen Hospital for admissions on 3 and 5 October 2010. On 5 October at two in the afternoon he was brought in to Bowen Hospital by police pursuant to an emergency examination order. The hospital notes recorded that he had pressured speech, flights of ideas, paranoid ideation, was emotionally labile, threatening harm to his ex-wife and anyone else who crossed him and stated that he was 'affluent one minute and broke the next'. Dr Lawrence noted that at that stage his behaviour was such that he required detention under the [*MHA*]. He was then transferred to Mackay Base Hospital where his manic behaviour, both subjectively and objectively, continued for many days, even after considerable medication.

[44] Dr Lawrence also considered that the medical records indicate that the elevated mood and the delusional beliefs, which were present both shortly before the offending and for some considerable time after the offending behaviour, were obviously evident, even in the presence of treatment.

[45] Dr Lawrence indicated that her clinical advice was that Mr Bosanquet at the time of both offences on 4 and 5 October 2010 was suffering from an acute episode of mania and a bipolar affective disorder of some months duration and he was so affected by his psychotic beliefs that he committed the offences of both stalking and arson at that time. Dr Lawrence

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22 As already mentioned and explained below, this also does not accord with Dr Grant's evidence concerning the deprivation of the respondent's capacity for control, in respect of which he considered intoxication could not be excluded as contributing to the deprivation of capacity.

> concluded that he was deprived of the capacity to know that he ought not to do those acts at that time. She also considered that as a result of his delusional beliefs and his arousal he was also deprived of the ability to control his behaviour as a result of his manic illness. In her view intoxication did not contribute to any extent to the offending behaviour which was driven by his mental state at the time."[23]

[36] Although not included in the MHC's summary of Dr Lawrence's advice, she also gave advice concerning the evidence given by Dr O'Sullivan as follows:[24]

> "… Dr O'Sullivan expressed the view that Mr Bosanquet presented with a classical mania at the time of the offences and was of the opinion that they were driven by the delusional belief which deprived him of control over his behaviour essentially, though he seemed to implicate some problems with knowing that he ought not to do the act as well. Dr O'Sullivan pointed out that excessive alcohol and drug use is often secondary to mania itself. He did not regard intoxication as contributing to the mental state that drove the offences. He believed that the illness was very apparent, both before the offences and that for some time afterwards. He believed that Mr Bosanquet's own reports about his alcohol and cannabis use at the time and his attribution of those intoxicants to his offending behaviour were themselves probably exaggerated, consistent with his mania. Dr O'Sullivan therefore maintained his opinion that the offences were the result of his delusional beliefs a product of the mania."

[37] Dr Davison, the other assisting psychiatrist, did not provide any additional advice of his own at the conclusion of the hearing of evidence and submissions, indicating only that he was in "complete agreement" with Dr Lawrence's advice. However, he made some observations during the hearing,[25] which the MHC referred to at [39], to the effect that the full blood count result indicated a reading in relation to alcohol use which was within the normal range, and which would not support the notion of long-term alcohol abuse.

The MHC's finding as to intoxication

[38] Having concluded that the respondent suffered from a mental illness at the relevant time, the MHC identified the next question to be considered as whether the respondent's state of mind resulted to any extent from intentional intoxication. The MHC stated:

> "[52] … It is clear that the definition of 'unsound mind' indicates that a finding of unsoundness is not available if the state of mind resulted to any extent, from intentional intoxication or stupefaction alone or in combination with some other agent at or about the time of the alleged offence.

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23 No objection was taken as to whether this advice went beyond the scope of s 389(1)(c) (see *Reid v DPP (Qld) & Anor* [2008] QCA 123 at [44]-[47]; *DAR v DPP* [2008] QCA 309 at [96]), rather it was argued on appeal that the advice approached a deliberative role on the issue of intoxication: Appeal Transcript 1-15.

24 AR 116-117.

25 AR 24.

> [53] The assisting psychiatrists as well as Dr Sullivan (sic) and Dr Grant do not consider that there is any reliable, objective evidence about intoxication. I also note that none of the contemporaneous reports by police or medical personnel refer to alcohol or recent drug use. I also consider that due to the period of time over which the arson offences are alleged to have occurred it is also unlikely he was intoxicated whilst driving to the caravan park or whilst he was actually concealed at the caravan park.
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> [54] Neither is it appropriate to rely on Mr Bosanquet's self report about his level of consumption. Dr Sullivan (sic) stated that initially Mr Bosanquet told him that he could not recall if he had been drinking. Dr Sullivan (sic) noted that Mr Bosanquet is now very contrite about what he did and he considers that Mr Bosanquet may be trying to justify or understand his behaviour by blaming it on alcohol.
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> [55] It would seem clear to me therefore that there is no objective evidence that Mr Bosanquet had in fact been drinking or consuming substances to the extent that he was intoxicated at the time of the alleged commission of the offences. I am not satisfied therefore that intoxication in fact played any role in the deprivation of any of the capacities."

The MHC's consideration of the issue of deprivation

[39] The MHC then addressed the matter of the deprivation of capacity, observing at [56] that what was required was that "the mental disease must be such that it actually deprives a person of one of the three relevant capacities". The MHC identified the "real question" as "whether the state of mental disease was such that [the respondent] was actually deprived of one of the relevant capacities because of that mental disease". In that regard, the MHC adopted dicta in *Re W*,[26] stating:

> "[56] … as Dowsett J explained in *Re W* 'the incapacity or infirmity must have (probably) actually deprived the accused of the relevant capacity at that time' and that it is not a question of determining whether the mental disease was such that it was 'sufficient' to deprive the person of responsibility.
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> [57] There must therefore be an examination of the nature of the illness and the nature of the act which is under consideration to ascertain whether the actual nexus required by the section has in fact been established. That is to examine whether there has been an actual deprivation of the relevant capacity because of the mental illness."

[40] It was accepted by the appellant that this was a correct articulation by the MHC of the relevant legal principle concerning "deprivation" of capacity; the complaint was as to its application.

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26 (unreported, Mental Health Tribunal, Dowsett J, 14 October 1997).

[41] The MHC also correctly identified that the three capacities referred to in s 27 of the *Code* are to be considered disjunctively. In that regard, the MHC adopted the dicta of Margaret Wilson J in *Re LIH*:[27]

> "[14] The 'state of mind' referred to in the second part of the definition of 'unsound mind' (beginning 'but does not include …') is a description of absence of capacity caused by mental disease. This part of the definition recognises that there may be more than one cause of a deprivation of capacity. The other cause (or causes) may be intentional intoxication or something else. If intentional intoxication plays any role in bringing about the deprivation, the state of mind does not amount to 'unsoundness of mind': that is what is meant by the words 'resulting, to any extent, from …'.
>
> [15] Mental illness may deprive someone of one of the capacities. Another capacity may be adversely affected by mental illness or by intoxication or by a combination of mental illness and intoxication (whether or not the intoxication is combined with some third factor). The extent (whether deprivation or mere impairment) and the cause or causes of the adverse effect on the second capacity cannot derogate from a finding of unsoundness of mind based on the deprivation of the first capacity."

The submissions before the MHC as to whether the respondent was deprived of a relevant capacity

[42] The MHC noted at [61]-[62] the submissions made by the respondent's counsel. It was argued that at the time of the charges the respondent was of unsound mind due to the deprivation of both the capacity to control his actions and the capacity to know that he ought not do the acts. It was submitted that his jealousy and anger were entirely based on delusional premises. The respondent could not rationally contradict that premise or the emotions that were informed by it because they were the product of a severe illness controlling his mind at the time. In particular, it was his illness alone which prevented the respondent from "reasoning with a moderate degree of sense and composure about his actions". At the time of the offences the respondent could not separate himself from his illness or from his delusions.

[43] The MHC also outlined at [63]-[68] the submissions advanced by the DPP, which focused on a number of factual matters that, it was argued, indicated that the respondent was not deprived of either of the relevant capacities. Reliance was placed on the derogatory messages left on his ex-partner's phone, which it was said indicated that the respondent had not lost control but was simply angry. Reliance was also placed on statements made during the second police interview, where the respondent accepted that he lit the fires as "pay back" and that he wanted to make a "statement". It was further contended that there was a degree of planning involved (the respondent hired a car, took petrol with him to light the fires and after lighting the fires he went to the back of the caravan park to wait and observe proceedings, then returned the car immediately on his return to Bowen). In his initial interview with police, the respondent sought to distance himself from the

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27 [2002] QMHC 14.

caravan park in Proserpine by saying that he was in fact in Bowen at the relevant time and that he would not use his small car on the highway. It was argued that the hiring of another vehicle, together with statements distancing himself from Proserpine, indicated that the respondent knew it was wrong to set fire to the caravans and that he ought not to do those acts, because he was trying to avoid detection. The level of pre-planning, the fact the respondent must have stayed hidden at the caravan park, as well as his statement to police that he could have turned around, supported the conclusion that he had capacity for control. The police interviews supported the conclusion that he was not deprived of any capacity because he understood what he was doing as he wanted to make a "statement" and he wanted a "pay back". That acknowledgement indicated that he must have known his acts were wrong.

The MHC's finding that the respondent was deprived of the capacity for control

[44] In respect of whether the respondent was deprived of the capacity of control, the MHC stated:

> "[75] In the present case it is true, as Counsel for the DPP submits, that there is evidence that some of Mr Bosanquet's actions were purposeful in that he could control his physical acts. The capacity for control however is not in my view simply about the capacity to control one's physical acts or 'motor control' it is actually to do with 'volition' which is whether that act is truly a willed act of the person in that it was an act they freely chose to do or whether it is an act driven by the delusions.
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> [76] The evidence of all the psychiatrists was quite clear that his actions on 4 and 5 October were driven by his delusional thinking.
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> [77] I consider that Mr Bosanquet's acts with respect to all 3 offences were driven by his delusional views about his ex-partner. I also consider that when the acts are examined they in fact show a lack of intelligent direction, which I consider confirms that his actions were obviously driven by his delusional thinking. This is obvious when the transcripts of the telephone calls are considered. Furthermore, buying petrol on the way to light a fire is hardly a rational thing to do if one is hoping to avoid detection. Similarly, lighting a second fire when police are in an adjacent caravan is simply foolhardy and in my view points to a lack of control. I also consider that Mr Bosanquet's actions in hiring a rental car in his own name is not in fact an action which is consistent with concealment given the paper trail involved in a car rental agreement. Rather, I consider that hiring a car so he could drive to Proserpine is evidence that he was so compelled to do the act that he hired a car to achieve his mission given his own car was not fit for the purpose.
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> [78] Accordingly whilst there was some planning it was either erratic or was in fact evidence of his disordered thinking. In

this regard I endorse the approach of Chesterman J (as he then was) in *Re McCulloch*[28] where his Honour found that there was a loss of a capacity for control even though some of the physical actions were purposeful around the time of the killing.

[79] I consider that Mr Bosanquet was deprived of the capacity of control at the time of the alleged offences on 4 and 5 October 2010."

The MHC's finding that the respondent was deprived of the capacity to know he ought not do the act

[45] The MHC dealt with the issue of deprivation of the respondent's capacity to know as follows:

"[80] It is clear that all of the psychiatrists consider that Mr Bosanquet was deprived of the capacity to know he ought not do that act. In response to questions at the hearing from Counsel for the DPP Dr Grant stated that Mr Bosanquet might have known that others would not have approved of his actions but that he felt justified in his actions. Counsel for the DPP argues that if Mr Bosanquet knew that others would not have approved of his actions then such knowledge would deprive him of the defence on the basis of this incapacity. It was argued that his own view about whether he felt justified or not is not relevant to the question of whether he was deprived of the capacity to know he ought not do the act. In this regard Counsel relied on Dowsett J's approach in *Re W* when he concluded that the defendant was deprived of a defence in circumstances which included evidence that he knew that others would view his actions as wrong.

[81] The conclusion in *Re W* obviously was based on the particular circumstances of that case and Dowsett J clearly does not alter the well known test as set out in *Stapleton v The Queen*[29] and extracted in the passages set out above. The test is whether Mr Bosanquet was able to appreciate the wrongness of the particular act he was doing at the particular time. Could Mr Bosanquet be said to know in that sense whether his act was wrong or was he unable because of his mental illness to think rationally of the reasons which to ordinary people make that act right or wrong? It is clear that the test places the focus not on knowledge but on the capacity to reason. As Dixon J said in *R v Porter*[30] 'We are not dealing with right or wrong in the abstract. The question is whether he was able to **appreciate** the wrongness of the particular act he was doing at the particular time.' (my emphasis)"

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28 (unreported, Mental Health Tribunal, Chesterman J, 26 February 1999).
29 (1952) 86 CLR 358.
30 (1933) 55 CLR 182.

[46] After referring to the discussion of the test in *Evans v The State of Western Australia*,[31] the MHC judge continued:

> "[83] In my view in the particular circumstances of this case I do not consider that Mr Bosanquet was able to think rationally because of his underlying mental condition namely a manic exacerbation of his underlying bipolar condition.
>
> [84] The prosecution also argues that in Queensland because of the additional 'volitional' capacity contained in s 27 the capacity to 'know one ought not do the act' does not contain a requirement that the person be able 'to reason with a moderate degree of sense and composure' or 'to reason calmly and rationally about the matter.' It is argued that adding such a requirement in Queensland creates a 'hybrid' test combining the capacities of 'control' and 'ought not do the act' into a single capacity 'that offers a defence that is broader than the sum of its parts'. It is argued that such a phrase adds an element of deliberative choice into the moral capacity question and that the deliberative choice aspect should be left within the domain of the 'control capacity'.
>
> [85] The extensive written submissions provided by Counsel for the DPP provides an extensive historical case analysis to support this submission with particular reliance on the reasoning in *R v Sodeman*.[32] I do not accept the submission from Counsel for the DPP that the test in relation to the capacity to 'know one ought not do the act' does not contain the requirement that the person be able to reason with a moderate degree of sense and composure. In my view there is clear authority that the test which is now challenged by Counsel for the DPP is the accepted test. It was clearly recently approved in *Evans*. The only note of caution related to instructions to the jury. The Court noted that the test may run the risk of confusing a jury because the real issue is not whether the accused is reasoning calmly and rationally but whether they are incapable of thinking in a rational way because of their mental condition.
>
> [86] I consider that Mr Bosanquet was deprived on the capacity to know he ought not do the act at the time of the commission of the offences on 4 and 5 October 2010."

Whether the MHC misapplied the concept of deprivation

[47] As mentioned, the appellant conceded that the MHC correctly set out the test as to deprivation at [56] and [57] in line with the approach in *Re W*. In *Re W* Dowsett J at p 14 analysed the meaning of the word "deprive" in s 27 of the *Code* as follows:

> "… I would like to say something about the phrase 'as to deprive'. There are three possible meanings attributable to it. A very broad approach would be to infer that the section requires the accused to

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31 [2010] WASCA 34.

32 (1936) 55 CLR 192.

> demonstrate that the commission of the offence was 'caused' by his or her mental condition. That approach cannot be justified by reference to the wording of the section. …
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> A second approach is to assume that the phrase is intended to describe the gravity of the incapacity or infirmity which will be sufficient to ground a defence. The defect must be so severe as to (probably) have been sufficient to deprive the accused of a relevant capacity at the time of the offence. This may be contrasted with the third approach which is that the incapacity or infirmity must have (probably) actually deprived the accused of a relevant capacity at that time. As a matter of language, the distinction is subtle, but the consequences for present purposes may be substantial. The former approach consigns a greater role to the expert medical witnesses. The latter confers a greater degree of responsibility on the tribunal of fact. This may be of importance in determining the extent to which this Tribunal or a jury considering a s 27 defence may allow its own assessment of the circumstances of the offence to weigh against expert opinion as to whether the offender was deprived of a relevant capacity at the time of the offence. See *R v Michaux* [1984] 2 Qd R 159 at p 164 and *R v Cannon* (unreported – CA 171 of 1997 – judgment delivered 26 September, 1997). The cases support the latter approach. *M'Naghten*, in the passage cited above, makes this clear. More recently, all members of the High Court in *Falconer* took that view (per Mason CJ, Brennan and McHugh JJ at pp 46-47, Deane and Dawson JJ at p 60, Toohey J at p 77 and Gaudron J at p 81)."

[48] The appellant's contention was that the MHC erred in that, in determining whether there was a deprivation of a relevant capacity for the purposes of the definition of "unsound mind", the test of "deprivation" was not correctly applied. By way of example, the appellant referred to the MHC's finding at [76] and [77] that the respondent's actions were "driven" by his delusional thinking when considering whether there was a deprivation of the volitional capacity. Further, the MHC was concerned with general reasoning powers in [83] when considering the relevant cognitive capacity. It was therefore contended that the MHC wrongly applied a general test of causation (the first approach) that had been disapproved by Dowsett J in *Re W*, in concluding that there was a deprivation of both of those capacities.

[49] The respondent argued that the MHC did not make such an error and that there was clear evidence from the psychiatrists that the respondent's actions were driven by his delusional thinking. It remained relevant and appropriate for the MHC to refer to that evidence. For, while the question of whether an accused person has, on the balance of probabilities, been deprived of a relevant capacity was a question of fact for the jury to determine in a criminal trial, and for the MHC to determine in matters referred to it, the opinions of suitably qualified medical witnesses carried significant weight.[33] The MHC's reasons made it clear that it in fact applied the correct tests and approach based on the authorities in finding that there was a deprivation of the two relevant capacities.

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[33] In that respect, reference was made to observations in *Stapleton v The Queen* (1952) 86 CLR 358 of Dixon CJ, Webb and Kitto JJ at 366-367.

[50] In respect of the finding that that there was a deprivation of the capacity for control, the respondent's counsel did not seek to sustain that finding on the basis of Dr Grant's evidence, conceding that his evidence did not support a defence on the basis of a deprivation of the volitional capacity, because he was unable on the balance of probabilities to exclude that the deprivation was not contributed to, to any extent, by intoxication.[34] It was submitted however that in respect of the capacity for control there was clinical evidence from Dr O'Sullivan that supported the finding of the MHC that the respondent was deprived of that capacity. As to the finding of deprivation of the capacity to know not to do the acts in question, the respondent contended that there was evidence from both expert witnesses that supported that finding.

[51] The argument raised by the appellant that there was an incorrect application of the test of deprivation will be considered separately with respect to each of the relevant capacities, together with other complaints raised particular to each capacity.

Whether there was error in the finding of a deprivation of the capacity for control

[52] The MHC adopted the analysis in *Re SAM*[35] where Margaret Wilson J correctly explained that the capacity for control in s 27 of the *Code* concerned volitional control:

> "The section is concerned with the criminal responsibility of a person deprived by mental illness of the capacity to control his or her physical acts. It is concerned with the loss of volitional control rather than motor control over physical acts."

[53] In *Re SAM*, Margaret Wilson J referred to the decisions of Dowsett J in *Re W* and in *Re B*[36] and particularly the dicta in *Re B* that, where there was evidence of premeditation and planning, it was "very difficult to conclude that the act was the result of an inability to control one's actions". In *Re SAM*, her Honour did not accept that evidence of premeditation and preparation was necessarily or even generally indicative of the presence of some capacity of control. Her Honour referred to advice from the assisting psychiatrists that "there can be cases of psychotic disorder, mania or other mental disease where the person affected is deprived of neither of the cognitive capacities, but is nevertheless deprived of the capacity of freely choosing whether or not to do an act". Her Honour found that the premeditation and preparation present in that case (fetching the chain and the rock and taking them to the deceased's home) were themselves driven by his delusional mood and psychotic thinking. As such it was not accepted that they were indicative of the existence of any capacity of volitional control.

[54] The appellant's complaint concerning the MHC's finding of deprivation of the volitional capacity was that in the present case, there was nothing in the nature of the respondent's delusion that his ex-partner was unfaithful that compelled the respondent, to the point of deprivation of the power to resist stalking and arson. The matter raised was one ventilated at first instance. As occurred at first instance, emphasis was placed on the respondent's degree of planning (hiring a car and purchasing petrol) and his concealment between the two arsons, his lying to police about his conduct and his statements to police of "pay back", as incompatible with

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34 Appeal Transcript 1-34, 1-45.
35 [2003] QMHC 3 at [31].
36 (unreported, Mental Health Tribunal, Dowsett J, 3 November 1997).

a finding of deprivation of control. The appellant submitted that, although command hallucinations will typically deprive a person of the power to control their actions, nothing of that sort was present in the instant case. There was nothing in the nature of a delusional belief involved in the present case that irresistibly compelled the consequent offending behaviour. It was thus contended that the MHC's conclusion on that point was derived from its application of the (wrong) "causation" test for deprivation.

[55] In making those submissions, the appellant contrasted the approach of the MHC with that taken by Dowsett J in *Re W* at p 15. However, each case is to be determined on its own facts and circumstances. It would not be appropriate to draw too close an analogy with *Re W*, which did not concern mania but a defendant who was suffering from delusional disorder. Furthermore, the appellant's argument that the MHC erred in not identifying how the respondent's delusion about his ex-partner in fact deprived him of the capacity for control in respect of all of the alleged offending, overlooks the clinical evidence of the respondent's broader manic condition, and its relevance in terms of the deprivation of the capacity. Dr O'Sullivan's evidence was that the respondent was in a manic swing of a well-recognised bipolar disorder, characterised by persecutory delusions which, in the instance in question, were focussed on his former partner. His evidence was that at the relevant times the respondent was "misconstruing reality to the extent that he was clearly psychotic"[37] and that when he was "consumed with various paranoid delusional negotiations" it was "all consuming and he has no frame of reference with reality whatsoever."[38] Dr Grant's evidence was that mania frequently resulted in a deprivation of control because of the intense elation or stimulation, anger, grandiose delusions, paranoid ideas; and that one may lose control but still be able to put a plan into effect.[39] Although the MHC largely referred to the respondent's delusional thinking when discussing the deprivation of control in the analysis at [76]-[78], rather than the respondent's mania, it was clearly a matter to which the MHC was alive and had referred to specifically elsewhere (as is apparent from [83] and particularly the summary of the experts' evidence and Dr Lawrence's advice at [42]). It was implicitly the basis for comments in [76]-[78]. Accordingly, I do not consider that there is cause for complaint on that basis.

[56] As to the complaint made by counsel for the appellant in terms of the MHC's consideration of issues to do with pre-planning and the supposed alibi, there was evidence from Dr Grant that those matters did not necessarily mean that one ought to discount the influence of illness on a person's behaviour.[40] A loss of control did not mean that one could not put into place "a series of events".[41] Dr Grant stated that lighting the second fire, presumably knowing that the police were not very far away, suggested further loss of insight and control over the respondent's behaviour.[42] There was expert evidence to support the conclusion reached by the MHC that, in the circumstances of the present case, the element of planning, concealment and supposed alibi did not preclude a deprivation of capacity.

[57] The other argument made by the appellant in contending that the MHC applied an incorrect test in finding a deprivation of the capacity has already been referred to. It

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37 AR 10.
38 AR 13.
39 AR 88.
40 AR 93.
41 AR 54, 64.
42 AR 53.

was said that the MHC relied on evidence which fell short of the requisite test of "deprivation" and reflected a broad causative view discredited in *Re W*. In that regard, it was said that the MHC fell into error by overly focussing on expert evidence referred to at [76] and [77] that the respondent's conduct was "driven" by his delusional thinking and advice that the conduct was "motivated" by the mania.[43] Likewise, it was said that the MHC was led into error by relying on Dr O'Sullivan's evidence that the respondent's "illness itself was sufficient for the respondent to behave in the manner that he did" and that his "behaviour was accountable for" in terms of his being psychotic and manic with or without alcohol being involved,[44] and to similar comments extracted in the MHC judgment at [17]. The summary of Dr O'Sullivan's evidence at [10], that he considered the respondent to be deprived of the capacity for control, was also said to be in that category.

[58] The question for the MHC was whether the respondent's mental illness was such that it deprived the respondent of a relevant capacity. Caution should be exercised with respect to terms such as "driven" or "accountable" when they are used to describe the role played by a mental illness in respect of proscribed conduct. Such descriptions may refer to a general causative explanation of the conduct, without identifying whether, at the relevant time, the extent of the mental illness was such that there was a consequent absence of capacity. Such descriptions may therefore mask the distinction between an absence of capacity (deprivation) and something less (for example, substantial impairment). Without further clarification, such descriptions may not assist the MHC in identifying, with the rigour required, whether at the material time the mental illness actually resulted in a deprivation of a capacity.[45] Likewise, care must be taken in considering evidence that a person's mental illness was "sufficient" to have resulted in a deprivation of a capacity. Clinical evidence that a person's mental illness was sufficient to ground a defence may fall within the second category referred to in *Re W* (as relevant clinical evidence of the severity of the mental illness) and thus be of some assistance. But where the question of intoxication is raised, evidence that an accused person would have been experiencing a state of mental illness resulting in a deprivation of capacity, even if not consuming intoxicating substances may be problematic because it blurs a proper consideration of whether the relevant deprivation was contributed to, to any extent, by intoxication and thus provide an inadequate basis for the MHC to reach a finding of unsoundness of mind: see *Reid v DPP (Qld) & Anor*.[46]

[59] It may be accepted, as counsel for the respondent submitted, that the clinical evidence of the severity of the respondent's illness and its sufficiency to explain his conduct remained relevant to the MHC's deliberation. However, as the appellant contended, a focus on such evidence resulted in an erroneous application of principle. In this regard, there is a difficulty in relying on Dr O'Sullivan's evidence in support of the MHC's finding of deprivation of the volitional capacity because his evidence as a whole did not support the conclusion that there was in fact

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43 In that regard, complaint was made by the appellant of Dr Lawrence's advice recorded in the MHC judgment at [42].

44 AR 12, 14.

45 Clarification was particularly pertinent given Dr O'Sullivan's evidence that the respondent's conduct was "predominantly" the result of his mental illness: see [88]-[89] below.

46 [2008] QCA 123 at [30] and see discussion below at [104]-[105]. In this regard, the appellant made reference to the line of questioning at AR 44, which the appellant argued was directed to a causative approach and not to the question which the MHC was required to determine. However, Dr Grant in giving his evidence appeared to have been alive to the difficulties with such an approach: see AR 45.

a complete absence of capacity. It is clear, as counsel for the respondent submitted, that Dr O'Sullivan did opine in his two reports that there was a deprivation of control and that he also gave oral evidence to that effect, stating that the respondent "lost that capacity of control",[47] "had no control … from the beginning to the end" and "had no control over his conduct or his thinking or his actions that were consequent upon his thinking."[48] But that opinion was qualified by subsequent evidence, which was not referred to by the MHC. When further pressed on the matter, Dr O'Sullivan gave evidence that the respondent had "limited control" over his actions and that he did not know how much capacity the respondent had, but that on the respondent's history of a previous episode and on Dr O'Sullivan's reading of the episode in question, "the amount of capacity he has is less than enough and is severely impaired and … it explains the conduct".[49]

[60] The presence of some (even limited) control is inconsistent with a deprivation (absence) of capacity, and the concept of severe or substantial impairment is not sufficient for a finding of unsoundness of mind.[50] Insofar as the MHC relied on Dr O'Sullivan's evidence in support of a finding that there was in fact a deprivation of the capacity for control, there is merit in the appellant's argument that it approached the issue by applying an incorrect test as to the issue of "deprivation". There was also a further difficulty in relying on Dr O'Sullivan's evidence, given his statements to the effect that the respondent's behaviour was "predominantly" determined by his mental illness (which are dealt with below when considering the issue of intoxication).

[61] Nor does Dr Grant's evidence provide support for the MHC's finding. Dr Grant gave somewhat varying evidence on the matter of deprivation,[51] but his final position was that at the time of the alleged offences there had been a deprivation of control.[52] However, as counsel for the respondent conceded, and as explained in detail below, Dr Grant was unable to support a defence on the basis of a deprivation of the volitional capacity, because he was unable to exclude that the deprivation was not contributed to, to any extent, by intoxication. In that respect, Dr Grant's evidence did not accord with the summary of his evidence outlined by the MHC at [28], nor with Dr Lawrence's summary of his evidence as expressed at [42].

[62] The appellant's argument that the MHC's finding of deprivation of the cognitive capacity proceeded on an erroneous application of the test of deprivation is made out. In my view, the MHC erred in fact (given the misstatement of the expert evidence of Dr Grant) and law (in failing to apply the proper test in respect of Dr O'Sullivan's evidence) in concluding that there was clinical evidence to support a finding of unsoundness of mind on the basis of the deprivation of the capacity for control.

Whether there was error in the finding that there was a deprivation of the capacity to know not to do the acts in issue

[63] The classic statement of the test concerning deprivation of the capacity to know one ought not to do an act, is the test as put to the jury by Dixon J in *R v Porter*.[53]

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47 AR 13.
48 AR 16.
49 AR 18.
50 It only has relevance for diminished responsibility, which was not applicable in the present case.
51 See AR 47 c/f AR 88.
52 AR 89.
53 (1933) 55 CLR 182 at 189-190.

Having observed that the test is not one of right or wrong in the abstract, his Honour stated:

> "… The question is whether [the accused] was able to appreciate the wrongness of the particular act he was doing at the particular time. Could this man be said to know in this sense whether his act was wrong if through a disease or defect or disorder of the mind he could not think rationally of the reasons which to ordinary people make that act right or wrong? If through the disordered condition of the mind he could not reason about the matter with a moderate degree of sense and composure it may be said that he could not know that what he was doing was wrong. What is meant by 'wrong'? What is meant by wrong is wrong having regard to the everyday standards of reasonable people."

[64] The *Porter* test was endorsed in *Stapleton v The Queen,*[54] where it was stated:

> "… A case of this description must turn very largely upon the jury's appreciation of what amounts to knowledge of the nature and quality of the act and of its wrongness. For it is evident that a jury although satisfied that no capacity existed in a particular accused to reason at all may think that at the back of it all was an awareness of the nature of the act and of the fact that other people might regard it as wrong more especially if that means regarded by the law as wrong. That would not lead to a conviction if the jury understands that, given a disease disorder or defect of reason, then it is enough if it so governed the faculties at the time of the commission of the act that the accused was incapable of reasoning with some moderate degree of calmness as to the wrongness of the act or of comprehending the nature or significance of the act of killing."

[65] As was also observed in *Stapleton*,[55] an awareness that an act is punishable by law is not necessarily inconsistent with an insanity defence:

> "… in certain cases, where the insane motives of the accused arise from complete incapacity to reason as to what is right or wrong (his insane judgment even treating the act as one of inexorable obligation or inescapable necessity) he may yet have at the back of his mind an awareness that the act he proposes to do is punishable by law."

[66] The *Porter* test refers to an inability to "reason about the matter with a moderate degree of sense and composure" and, as Dowsett J observed in *Re W*,[56] the context "makes it clear that the word 'matter' is the rightness or wrongness of the act in question". Furthermore, the inability to reason must be due to the person's mental condition. There is no complaint about those aspects of the expression of the test by the MHC at [81], nor was issue taken with the MHC's rejection of the legal argument recorded at [84]. It was the respondent counsel's submission therefore that the MHC applied the correct and accepted test, based on *R v Porter*, and that the finding that, on the balance of probabilities, there was a relevant deprivation was supported by the opinion evidence of Dr O'Sullivan and Dr Grant and the advice of the assisting psychiatrists.

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54 (1952) 86 CLR 358 at 367.

55 At 375.

56 (unreported, Mental Health Tribunal, Dowsett J, 14 October 1997) at 13.

[67] The appellant, however, contended that, while the MHC's conclusion that there was a deprivation of the cognitive capacity was consistent with the psychiatric opinion, the opinion was based on an erroneous understanding of legal principle which flowed through to the judgment. The crux of the appellant's submission was that the MHC fell into error by failing to identify the link between the mental illness and the deprivation of the relevant cognitive capacity. In particular, more was required than a mere subjective sense of entitlement to satisfy the deprivation of the relevant cognitive capacity; many non-impaired offenders have a sense of entitlement to commit an offence, even though they know it is wrong by ordinary standards, particularly in the area of failed relationships. In this context, reliance was placed on Dr Grant's evidence that at the relevant time the respondent probably believed others would consider his actions wrong.[57]

[68] The appellant submitted that it may be that in many psychiatric cases it is not helpful to ask whether an accused person knew that a particular act was against the law, or knew that other people would think his actions were wrong. An accused's delusion may have built into it a "higher" moral code which, in the mind of the accused, supersedes that of ordinary thinking; a belief that one is God or that one has special instructions from a delusional moral authority are examples. But it was argued that nothing like that emerged in the present case and the respondent's delusion did not extend beyond one that his partner was unfaithful. Accordingly, asking whether the respondent knew that others would consider his actions wrong was a significant indicator of his own capacity for moral reasoning. Dismissing the value of asking whether an accused knew that others would consider his actions were wrong, it was said, resulted in the matter being dealt with at too general a level of abstraction and obscured the distinction between the content of the delusion, and the reasoning which flowed from that delusion to the offending act. Thus, it was said in respect of the deprivation of the cognitive capacity, the MHC erred by also applying the "causation" test to the question of deprivation and failing to embark on a proper examination of the relationship between the illness and the behaviour.

[69] In terms of the evidence concerning the relationship between the respondent's mental illness and the alleged offences, Dr Grant did in part explain the respondent's deprivation of the cognitive capacity in terms of his delusion about what was going on between his former partner and the male complainant, and in terms of the respondent acting "on that delusion, and being so distressed about his belief that he couldn't think calmly and sensibly about what he was doing and that he was deprived of the capacity to know that he shouldn't do that act even though it happened over a period of time."[58] Dr Grant also opined that whether there was a deprivation of "moral understanding of his actions" depended on "how significant the respondent's delusional ideation about his ex-wife and the male complainant was."[59] Dr Grant further opined that, notwithstanding that the respondent might have known at the time of the offences that what he was doing was illegal and perhaps that others might not have approved, the respondent might still have been deprived of the relevant cognitive capacity through the intensity of his illness; that is the strong personal belief driven by his illness that he had the right to act as he did.[60] I note however that, while Dr Grant stated that at the time the respondent

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57 AR 75-76.
58 AR 64. See also AR 91.
59 AR 80.
60 AR 83.

committed the offences he probably believed others would consider his actions to be wrong,[61] he subsequently qualified that statement. Dr Grant added that "certainly [the respondent] considered the police might think that … by giving them alibis and other accounts of what he did, and that might well extend to other people in the community, I don't know".[62]

[70] Moreover, Dr Grant went on to explain that the respondent's conduct arose not only from his delusional belief that his former partner and the male complainant were having an affair, but also his wider delusions as to what was happening in the world and "all of his manic symptoms".[63] In other words, Dr Grant considered that the conduct needed to be understood in the context of the respondent's broader mania and delusional belief system, which had reached psychotic levels. The question of personal entitlement arising from the respondent's delusional thinking must therefore be seen in that broader context. Dr Grant thus commented that whether the respondent was deprived of moral understanding of his actions depended not only on the intensity of the respondent's delusional ideation about his ex-wife and the male complainant, but had to be considered "in the context of a manic illness where he is very overactive, his thoughts are racing, he's feeling paranoid generally about … other paranoid beliefs."[64] As mentioned, the MHC was alive to the significance of the respondent's mania which was referred to at [83].

[71] Dr Grant's ultimate opinion, given on the first day of the hearing was that, in relation to all of the offences and having regard to all of the evidence, including hospital records and the evidence presented in court, "in terms of the capacity to know he ought not do the act … one could say on the balance of probabilities that it was the illness depriving [the respondent] of that capacity at the time".[65] He maintained that view when the MHC resumed the hearing on 2 November 2011, opining that, "It was very likely that [the respondent] was, on the basis of his illness, deprived of the capacity to know he ought not do the act" and "that the illness was depriving him of that capacity in a moral sense".[66] I note that Dr Grant expressed some caution about real events in the respondent's life that were causing him to feel stress and anger, but he did not resile from his earlier opinion that it was the illness alone that deprived the respondent of the relevant cognitive capacity.[67]

[72] In relation to the clinical evidence given by Dr O'Sullivan, although he made some statements suggesting that there was an impairment of the cognitive capacity, as opposed to a deprivation of it,[68] his final view, which was referred to by the MHC, was that at the time of the alleged offences the respondent's illness was governing his thinking to the extent that he was unable, with a moderate degree of sense and composure, to think rationally of the reasons which, to ordinary people, would make those offences right or wrong.[69]

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61 AR 75-76, 78, 80.
62 AR 80.
63 AR 65.
64 AR 80.
65 AR 59, 64.
66 AR 87.
67 AR 91.
68 AR 18.
69 MHC judgment at [11]; AR 106. He did not consider it possible to determine whether the respondent's conduct in avoiding being detected suggested that he knew his actions in lighting the fire were wrong: AR 106.

[73] An additional argument was that the MHC erred in attaching too much importance to the question of the ability to reason "with a moderate degree of sense of composure". It was said that the MHC thereby erred in focussing on the respondent's general reasoning powers rather than on whether the respondent was incapable of reasoning about whether his conduct was wrong according to the standards adopted by ordinary people. It was argued almost no patient, by definition, is reasoning with sense when they are suffering from a delusion. The complaint was directed to [83]-[85] of the MHC judgment. While the MHC referred in those passages to the ability to reason "with a moderate degree of sense and composure" and to "incapacity of thinking in a rational way", it is abundantly clear from what was said at [81] and [82] that the MHC was implicitly referring to the respondent's incapacity to reason about "the wrongness" of the conduct according to the standards adopted by ordinary people, and not simply to his general reasoning ability.

[74] Leaving aside the issue of intoxication as it impacts on Dr O'Sullivan's evidence of deprivation of capacity (discussed below), I do not consider that the clinical evidence proceeded on an erroneous appreciation of legal principle concerning the cognitive capacity as contended. In my view, it would not be correct on the totality of the clinical evidence to conclude that there was an insufficient basis for the MHC's finding at [86] that there was a deprivation of the cognitive capacity, absent intoxication.

The issue of intoxication

[75] The MHC found at [55] that there was no objective evidence of consumption to the extent that the respondent was in fact intoxicated at the time of the alleged offending and accordingly, intoxication in fact played no role in the deprivation of any capacity.

[76] The appellant contended that there was a barrier to the MHC's proceeding with the reference in the present case, arising out of the application of s 269 of the *MHA* because there was a fact substantially material to the opinion of an expert witness so in dispute that it would be unsafe to make a decision as to unsoundness of mind. In the present case that fact was said to be the extent of the respondent's alcohol and drug consumption and whether the respondent was intoxicated at the time of the offending. It was submitted that the MHC's finding that the respondent was not intoxicated at the relevant times, entailed embarking on a fact-finding exercise which discounted the respondent's contemporaneous self report in the absence of objective evidence. It was also said that the emphasis by the MHC on the absence of "objective evidence" of intoxication in effect imposed a requirement that the prosecution demonstrate the presence of objective evidence which was inconsistent with the necessary restraint provided for in s 269, and probably inconsistent with the onus of proof provision (s 405). It was submitted that the MHC ought to have proceeded on the basis that the respondent had consumed significant amounts of alcohol and cannabis and that he was, on the balance of probabilities, intoxicated. Had the MHC proceeded on that basis, it was not contended that s 269 would have precluded determination of the further issue of whether intoxication contributed to a deprivation of a relevant capacity.

[77] Counsel for the respondent argued that, on a proper consideration of all of the relevant evidence on the issue of intoxication, there was no fact so in dispute within

the meaning of s 269 that the MHC was precluded from determining the reference. Moreover, there was a firm basis on the evidence for the conclusion at [55]. It was acknowledged that the respondent told police and others that he was intoxicated at the time to a high degree and that he had been drinking, and, in addition, consuming cannabis for some time prior to the offences. But in forming their opinions, the psychiatrists disputed the respondent's account. The psychiatrists purported to come to their own conclusions about whether or not the respondent's admissions and attribution of his conduct to intoxication were reliable. In this regard, it was apparent from the MHC's review of the evidence of Dr O'Sullivan[70] and Dr Grant,[71] concerning the respondent's self reports about drinking and marijuana use, that both doctors took into account as a significant factor that the respondent's psychotic symptoms continued in the absence of intoxicants for three weeks after his admission to hospital.

[78] When considering the issue of intoxication, it is important not to conflate the question of whether the respondent was on the balance of probabilities intoxicated at the material time with that of whether intoxication contributed to any extent to the relevant state of mind.

[79] The MHC at [52] correctly noted that a finding of unsoundness is not available if "the state of mind resulted to any extent, from intentional intoxication or stupefaction alone or in combination with some other agent at or about the time of the alleged offence". The MHC, as mentioned, referred to dicta in *LIH* that if intentional intoxication "plays any role in bringing about the deprivation, the state of mind does not amount to 'unsoundness of mind': that is what is meant by the words 'resulting, to any extent, from'…".

[80] In determining the issue of intoxication, the MHC took into account the following matters set out at [53]-[54]:

(a) The assisting psychiatrists, as well as the expert witnesses, Dr O'Sullivan and Dr Grant, did not consider that there was any reliable, objective evidence about intoxication.

(b) None of the contemporaneous reports by police or medical personnel referred to alcohol or recent drug use.

(c) Due to the period of time over which the arson offences were alleged to have occurred, it was unlikely the respondent was intoxicated whilst driving to the caravan park or whilst he was actually concealed at the caravan park.

(d) It was inappropriate to rely on the respondent's self report about his level of intoxication, given Dr O'Sullivan's evidence that the respondent initially told him that he could not recall whether he was drinking and Dr O'Sullivan's evidence that the respondent had become very contrite and might have been trying to justify or understand his behaviour by blaming it on alcohol.

[81] It is useful at this stage to set out relevant aspects of the evidence of Dr O'Sullivan and Dr Grant concerning intoxication and its role in the deprivation of capacity.

Dr O'Sullivan's evidence on intoxication

[82] In Dr O'Sullivan's initial report of 28 January 2011, he recorded the respondent's alcohol and drug history as "report six pack beer few times a week" and "smokes up

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70 At [13]-[18].

71 At [23]-[34].

to 20 cones per day". Given the reported use of alcohol and drugs, the doctor was asked by the MHC Registry to clarify whether the respondent was intoxicated at the time of the offences. Dr O'Sullivan provided a clarifying email dated 24 February 2011 where he stated, "It is not uncommon when manic or depressed for patients to seek out alcohol or other drugs. I do not know if at the time of the offences he was intoxicated or not. Even if he was intoxicated at the time, I still think that I still (sic) he would have been deprived of the capacity to control his actions in the absence of such intoxication, that is on the basis of his Bipolar disorder alone." Dr O'Sullivan provided a further report dated 14 April 2011 which was largely in the same terms as the previous report, however, under the heading "psychiatric history", there was no mention of drug and alcohol history, apart from the statement that the respondent "was treated for bipolar illness although history of marijuana and alcohol use was noted as well".

[83] In his second report Dr O'Sullivan continued to support a deprivation of the capacity for control, stating the respondent was labouring under several paranoid delusions at the time and his insight and judgment were seriously impaired. He added, "as a result of his psychotic confusion he now has poor or impaired recall of these events".

[84] Dr O'Sullivan considered there was no objective evidence about the respondent's state of intoxication, "either from nursing notes or from a blood screen or a urine test or something else".[72] Dr O'Sullivan's attention was drawn to entries in the medical records, particularly, the reference in the discharge summary of the Mackay Base Hospital Mental Health Unit, dated 2 November 2010, which referred to physical findings, including "UDS at admission cannabis plus, on day of d/c cannabis plus". The MHC sought the assisting psychiatrists' interpretation of those physical findings. Dr Lawrence offered the opinion that the urine drug screen did not support the respondent's self report and indicated that the amounts the respondent claimed to be using were inflated.[73] Dr O'Sullivan was asked his view and agreed that that was "a reasonable conclusion".[74]

[85] Dr O'Sullivan gave evidence that there was "no way of assessing [the respondent's] alcohol or drug effects apart from, you know, his own confession subsequently which I, myself, doubt."[75] Dr O'Sullivan also stated that he would not rely on the self report by the respondent of his own alcohol and drug abuse, observing that when he initially spoke to the respondent, the respondent was showing quite a considerable amount of contrition and making all sorts of apologies; he was feeling sheepish, guilty and morose and was somewhat depressive.[76]

[86] Notwithstanding Dr O'Sullivan's evidence that there was no objective evidence as to intoxication and that the respondent's accounts were unreliable and subsequent accounts were given when contrite, Dr O'Sullivan also gave evidence indicating he accepted and considered it likely that the respondent had consumed very large quantities of intoxicating substances prior to the events in question. In that regard, Dr O'Sullivan stated that, when manic, the respondent had close to no control over

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72 AR 11-12.

73 AR 24. This opinion is referred to at the beginning of the summarised advice of Dr Lawrence. The appellant contended that Dr Lawrence erroneously regarded the result as a quantitative rather than a qualitative result.

74 AR 25.

75 AR 14.

76 AR 12.

his consumption of intoxicating substances[77] and that he engaged in "completely out of control drinking during the manic episode, and he takes to alcohol and marijuana."[78] That evidence accorded with the respondent's reports on 5 October 2010 to medical officers of heavy alcohol and marijuana use.[79] Moreover, Dr O'Sullivan indicated that that was the respondent's usual pattern when manic, which he took pains to verify:[80]

> "*I explored that particular situation with him, in his previous episodes, that was, in fact – he verified that that was the clinical reality. That when he becomes unwell he consumes large amounts of drugs, particularly alcohol and marijuana* -----
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> …
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> -----and – and he doesn't seem to have the patterns of chronic alcoholism and chronic marijuana use. It does seem to emerge at particular times and when he is, effectively, unstable. That's certainly with the history that I managed – I was – *I'd made an effort to get that particular history from him without leading him too much to it … and I believe that is his history*." (emphasis added)

[87] In respect of the respondent's report to Dr Grant that he blamed intoxication with alcohol and marijuana for his conduct, Dr O'Sullivan explained: [81]

> "I think that it might not be in his interest to blame intoxication …the history was pretty much quite clear that it wasn't alcohol and marijuana that had caused the derailment of his sanity over a number of weeks and months … And [the defendant] might have felt that was all the grog and the drugs but I have a hunch that that was ... a not very useful thing for him to say for himself because the fact of the matter is, he was quite clearly mentally ill *prior to the use of drugs and alcohol in those extreme amounts*, which is not … his habit, as I understand it.
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> …
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> [I]n the broader context this was a man who was quite unwell and was mentally ill, clearly demonstrably mentally ill prior to these events emerging … And *that as is his usual pattern when he's manic, he started consuming massive amounts of alcohol and marijuana which just made the paranoia and ... the poor judgment worse*. He simplistically blamed that as the cause of everything but I think this whole matter was well and truly on-foot some weeks and months prior and that's my judgment." (emphasis added)

[88] Dr O'Sullivan's view, as the MHC noted at [18], was that, if all of the respondent's conduct were accountable just simply in terms of alcohol intoxication and marijuana effects, he would have expected his mental state to settle sooner as those substances were out of his system and metabolised in possibly a week but not three weeks. However, Dr O'Sullivan also added:[82]

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77 AR 14.
78 AR 26.
79 AR 349, 372.
80 AR 31.
81 AR 27-28.
82 AR 29.

> "… So it helps to confirm, in my view, that the *predominant* picture here is of … a mentally ill man who had a recurrence of manic psychosis which required the usual two to three to even four weeks for the symptoms to be treated appropriately with mood stabilisers and anti psychotics." (emphasis added)

[89] Dr O'Sullivan gave further evidence on 2 November 2011 on the matter of intoxication and stated:[83]

> "[W]e don't know the extent to which alcohol and cannabis was impacting but my – I think my evidence in the past was that it *could be explained in its own right by the mental illness without having to revert to explanations from drugs and alcohol* and that my own view was that … *his behaviour was predominantly determined or affected by a manic episode* which clearly had begun several weeks before, continued throughout these – these events and certainly was observed as an inpatient to continue several weeks after whilst he was being treated for that manic episode." (emphasis added)

Dr Grant's evidence on intoxication

[90] Dr Grant was referred to but unable to express a view as to the significance of the notation "cannabis +" recorded on admission and on the discharge summary,[84] explaining that it would depend on whether the notation recorded exactly what appeared on the drug screen and more information would be required (such as the original path slips).[85] He was also referred to hospital notes which stated, "Smoke shitloads of pot, would smoke quarter a night". There was additionally some notation which he considered was able to be read as either "none lately" or "more lately". Dr Grant stated one would need the original author to say whether the notation read "none" or "more", explaining, "At first it looks like none, but I think it could be more, and if it was more lately that would be consistent with the history he gave me."[86]

[91] Dr Grant stated that, on the basis of the history that he received from the respondent, he considered intoxication was playing some role in the deprivation of capacity, but accepted that there were a number of difficulties with understanding the level of intoxication by either alcohol or marijuana.[87] He did not have the hospital notes when he completed his report and accepted that, on the basis of the hospital notes, the reliability of the history given by the respondent came into question.[88] Dr Grant said that, "having received the hospital notes, things are less clear in terms of my original opinion that intoxication was definitely a factor", but even so, he opined one would still have some concern about intoxication. [89]

[92] As to whether intoxication played a part in the deprivation of a relevant capacity, he considered alcohol intoxication would be seen to play a part mostly in terms of the capacity for control, rather than the cognitive capacity.[90] But he accepted that

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83 AR 101.
84 AR 363.
85 AR 40-41. See also AR 50 where Dr Grant considered it helpful for the urine drug screens to be obtained.
86 AR 42.
87 AR 45.
88 AR 46.
89 AR 47.
90 AR 48-49.

whether alcohol intoxication was a "very significant" factor was "shaky" on the objective evidence.[91] He also thought that, in relation to marijuana, there was a longitudinal picture that suggested that the respondent's illness occurred independently of marijuana.[92] He agreed that clinicians would consider the alleged offences related "primarily" to the manic illness.[93] When pressed by the respondent's counsel as to whether one should be sceptical about the reliability of the respondent's account of his intoxication in light of other accounts, Dr Grant stated:[94]

> "I'm not sure that I agree with that. I mean he was certainly intoxicated and says he had a high level of marijuana on testing a week before, that he was continuing to use alcohol and marijuana heavily, up until the time of the offence according to his history, and that would be consistent – his use of marijuana would certainly have been consistent with his past history. I don't think I would be able to say that he wasn't intoxicated or that, you know, it wasn't possibly relevant to the offences. But I'm certainly not saying that it was the only reason why he behaved in this way. Certainly he was manic and that was a very – very, very important reason to why he behaved in this way."

[93] As to whether the respondent's account should be considered unreliable given the objective evidence, Dr Grant indicated that the problem was that the objective evidence was patchy and uncertain.[95] Dr Grant also accepted that it was typical of mania to be grandiose when referred to the respondent's statements on admission.[96]

[94] As to the volitional capacity, Dr Grant maintained the view that intoxication was a contributing factor.[97] However, he stated, the fact that the respondent hired a vehicle, drove it to the caravan park and stayed there without revealing his purpose over a length of time suggested he was not "grossly intoxicated", accepting that disinhibition was part of his illness and not just related to alcohol.[98] But as already mentioned, Dr Grant was prepared to concede, in relation to all the offences, that given the totality of the evidence one could say, on the balance of probabilities, that it was the illness depriving the respondent of the capacity to know he ought not do the act at the material time.[99]

[95] The matter was adjourned *inter alia* so that enquiries could be made as to whether the urine drug screens could be obtained, together with other medical records.[100] At that stage Dr Grant's evidence appeared to support a finding of unsoundness of mind on the basis of a deprivation of the relevant cognitive capacity, but not as to the volitional capacity, in respect of which he was unable to rule out intoxication as a contributing factor.

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91 AR 47. Dr Grant did not consider there was strong objective evidence of chronic alcohol intoxication: AR 62.
92 AR 49.
93 AR 50. See also AR 44, 47
94 AR 58.
95 AR 59.
96 AR 63.
97 AR 55.
98 AR 60.
99 AR 56, 59.
100 AR 69.

[96] When the matter resumed on 2 November 2011, Dr Grant gave further oral evidence, having been provided with police interviews and other material.[101] As to the volitional capacity, Dr Grant reiterated the view that "in a manic state [the respondent's] control of his actions would be significantly impaired" but he believed that "if there was a loss of control – of capacity of control it was probably contributed to by intoxication".[102]

[97] Dr Grant was referred to inconsistencies in the medical records of 5 October 2010.[103] He again agreed that the respondent's accounts of ingestion could not be relied upon and opined that there had been a tendency, as the respondent recovered and got well, to attribute his behaviour to drugs and alcohol, "which may have been a false retrospective attribution. It was very hard to know as the accounts had varied a lot."[104]

[98] On the issue of the deprivation of the relevant cognitive capacity, Dr Grant reiterated that it was very likely that the respondent was "on the basis of his illness" deprived of the capacity to know he ought not do the act and that "the illness was depriving him of that capacity in a moral sense".[105] However, in respect of the deprivation of the capacity for control, Dr Grant was not prepared to support a defence, stating:[106]

> "[W]e don't know how intoxicated he was. He told me he was very intoxicated but his accounts have been quite inconsistent. If he was, indeed, very intoxicated, then I think that would have been – that's very relevant to the capacity of control. If he wasn't then the control issue comes back to the mental illness as the main factor and, certainly, it was severely compromised but whether it was deprived by the illness alone I find difficult to answer."

[99] Dr Grant noted that in the hospital records, "[I]t was stated on a couple of occasions by the medical people that he said, and they seemed to be thinking, that his control and his delusional state varied depending on how much marihuana he'd been using and that the intoxication might have been a relevant factor". Dr Grant therefore concluded because of the issue of intoxication, he couldn't "say that illness alone deprived him of control … but if there was no intoxication, as you said … then he may well have been deprived of control, but it's a bit hard to be sure exactly what was happening at that moment".[107]

[100] Dr Grant also gave the following evidence when asked "whether intoxication had an impact to any degree" and whether it would be "fair to say that we're really left with no objective evidence about that":[108]

> "We have *some objective evidence about intoxication in the period around then*. We know that about three days before when he had the car accident he was found to be intoxicated with alcohol and to have marijuana in his system. I don't understand the figures that were given there but he says that he was recorded to have a high level of

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101 AR 73. The record does not reveal what the other material comprised.
102 AR 77.
103 AR 84.
104 AR 83, 84, 86.
105 AR 87.
106 AR 88.
107 AR 89.
108 AR 94-95.

> marijuana in his system by the police. He was reported to have marijuana in his system on admission to hospital and on discharge from hospital but his accounts about alcohol intoxication as referred have varied a lot and the contemporaneous accounts seem to be that his alcohol intake was relatively moderate. Only later has he said that he thinks he must have been intoxicated with alcohol as well. So we have *objective evidence of marijuana intoxication which was chronic, which would have been present before the manic illness started and was continually there as well. Whether or not an escalation in marijuana had exacerbated his illness and his delusions is unclear from the evidence. I think it's very hard to know for sure. ...* In my view, *there isn't sufficient evidence to indicate heavy alcohol intoxication, then the marijuana intoxication is somewhat less relevant because it's chronic and it's been going on for years*." (emphasis added)

[101] Dr Grant was then asked by counsel for the Director of Mental Health to "disentangle for us to what extent her Honour and the assisting psychiatrists in this case should be worried about the question of alcohol intoxication", to which he responded:

> "Well, I think the evidence is so inconsistent and unreliable that it's impossible to say that he was *significantly* intoxicated with alcohol at the time. It's certainly, however, possible to say that he was very unwell and that that illness alone might be depriving him of the capacity to know that he ought not do the act."[109] (emphasis added)

[102] Dr Grant did not resile from his opinion expressed earlier as to the contributory role of intoxication on the volitional capacity. As already stated, Dr Grant's final view on the availability of a defence on the basis of a deprivation of the volitional capacity did not accord with the summary of his evidence outlined at [28], nor with Dr Lawrence's summary of his evidence as expressed by the MHC at [42].

Consideration

[103] In respect of the contemporaneous medical records, it would not be correct to conclude that none referred to "alcohol or recent drug use", rather the difficulty was that there were inconsistencies in the records. In Dr Grant's view, further information was required to understand aspects of the medical records. However, it is not clear whether any, and if so what, additional records or tests were able to be obtained. And no issue was raised by the appellant that there was any additional material or evidence in fact available that would provide a better understanding of the question of intoxication if the matter proceeded to a trial. In those circumstances, I do not consider that the state of the evidence as a whole, resulted in the issue of intoxication being so in dispute that the MHC ought not to have determined the reference, bearing in mind what was said in *Attorney-General of Queensland v Kamali*.[110]

[104] It is convenient here to refer to the appellant's submission that Dr O'Sullivan's evidence, that the "illness itself was sufficient for the respondent to behave in the

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109 AR 95.

110 (1999) 106 A Crim R 269 at 273.

manner that he did" and his "behaviour was accountable for" in terms of his being psychotic and manic with or without alcohol being involved,[111] distracted the MHC from the question that the MHC was required to determine. In that regard, the appellant referred to dicta of Keane JA (with whom White and Douglas JJ agreed) in *Reid v DPP (Qld) & Anor.*[112] In that case, in considering whether, at the time of the alleged offence, the state of mind of the appellant resulted "to any extent" from intoxication, Keane JA commented that "whether or not the appellant would have been experiencing a psychotic episode at that time even if he had not taken amphetamines is not the issue posed by s 267(1)(a) and the definition of 'unsound mind' in the Act".

[105] It is true that Dr O'Sullivan did not consider that there was objective evidence of intoxication at the material time and cast doubt on the respondent's account of the matter. However, his evidence, as I have set out (and as the MHC noted at [13]-[14]), proceeded on the basis that the respondent, in the context of his developing manic condition, had been consuming large quantities of alcohol and marijuana. His view appeared to be that the respondent's illness had developed in the context of the use of intoxicants.[113] In discounting the respondent's account as to the extent of his use of intoxicants on the basis of the absence of objective evidence, the MHC did not address the various statements of Dr O'Sullivan to the effect that the respondent was "consuming massive amounts of alcohol and marijuana". Nor did the MHC address Dr O'Sullivan's evidence that such consumption made the paranoia and poor judgment "worse". That evidence and his evidence that the "predominant picture" was of a recurrence of the respondent's manic psychosis, and that the behaviour in question was "predominantly determined or affected" by it, was at odds with a conclusion that intoxication did not contribute "to any extent" to the state of mind resulting in a deprivation of capacity.[114] And although Dr O'Sullivan gave evidence that there was a deprivation of the cognitive capacity (in that the respondent's mental illness was governing his thinking to the extent that he was unable, with a moderate degree of sense and composure, to think rationally of the reasons which, to ordinary people, would make those offences right or wrong), he did not state that the mental illness alone resulted in the relevant deprivation.[115] There was no clarification as to what extent intoxication also contributed to the deprivation.

[106] To the extent that the MHC's finding of unsoundness of mind proceeded on the basis that Dr O'Sullivan's evidence was that there was a deprivation of the cognitive capacity and intoxication played no role in that deprivation, there is substance in the challenge made by the appellant that that finding was arrived at erroneously by failing to apply correct legal principles. Nevertheless, when regard is had to Dr Grant's evidence, there is a sufficient clinical basis for a finding that mental illness alone resulted in the deprivation.

Conclusion

[107] Even accepting that there is merit in the appellant's submission that the MHC ought to have proceeded on the basis that the respondent was probably intoxicated at the

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111 AR 12, 14.
112 [2008] QCA 123 at [30].
113 See Dr Lawrence's advice – AR 116.
114 It was also at odds with the earlier opinion stated in the email of 24 February 2011: AR 201.
115 AR 106.

material time, there was support in Dr Grant's evidence for the finding of unsoundness of mind on the basis that the respondent's mental illness alone resulted in the deprivation of the relevant cognitive capacity, which opinion was endorsed by the assisting psychiatrists. My conclusion that Dr O'Sullivan's evidence did not provide a sufficient basis in law for a finding of deprivation of the relevant cognitive capacity therefore does not preclude this Court from confirming that aspect of the MHC's decision.

[108] As to the finding that there was a deprivation of the capacity for control, as explained, I do not consider that that finding can be sustained. There was no support for it from Dr Grant, as the respondent conceded, and the appellant's argument that the finding reflected an incorrect application of principle insofar as Dr O'Sullivan's evidence was concerned was made out, both because of the qualification Dr O'Sullivan made to his previously stated view by opining that the capacity was "impaired" and by his evidence that the mental illness was the "predominant" determinant of the conduct in question.

[109] Given that there was a basis on the evidence for the MHC's finding of unsoundness of mind, this Court ought to dismiss the appeal and confirm the decision of the MHC, albeit on the narrower basis that, at the time of the alleged offences, there was a deprivation of the respondent's capacity to know he ought not to do the acts in question. The orders of the court should be:

(a) Dismiss the appeal; and

(b) Confirm the decision of the MHC that the respondent was of unsound mind at the time of all of the alleged offences the subject of the references to the MHC.