CITATION: *Anne Margaret BRYANT v Edward John Kowcun* [2017] NTLC 032

PARTIES:	Anne Margaret BRYANT
	V
	Edward John KOWCUN
TITLE OF COURT:	LOCAL COURT
JURISDICTION:	Criminal
FILE NO(s):	21634093
DELIVERED ON:	21 December 2017
DELIVERED AT:	Darwin Local Court
HEARING DATES:	11 July 2017 & 02 November 2017
JUDGMENT OF:	Chief Judge John Lowndes

CATCHWORDS:

CRIMINAL LAW - DEFENCE OF MENTAL IMPAIRMENT UNDER SECTION 77 OF THE MENTAL HEALTH AND RELATED SERVICES ACT – THE SCHEME OF THE ACT – SUBSTANCE INDUCED MENTAL ILLNESS – PURPOSE AND EFFECT OF SECTION 77 CERTIFICATE – BURDEN AND STANDARD OF PROOF - EVALUATION OF EXPERT OPINION EVIDENCE

Mental Health and Related Services Act ss 6 and 77
Criminal Code s 43A
O'Neill v Lockeyer [2012] NTSC 10 followed
Mununuggur v Gordon & Anor [2011] NTSC 82 followed
Dasreef Pty Ltd v Hawchar (2011) 243 CLR 588

REPRESENTATION:

Counsel:

Prosecution:	Mr Rowbottam
Defendant:	Mr Jehne

Solicitors:

Prosecution:	DPP
Defendant:	NTLAC

Judgment category classification:	A
Judgment ID number:	[2017] NTLC 032
Number of paragraphs:	114

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

No. 21634093

BETWEEN:

Anne Margaret BRYANT
Plaintiff

AND:

Edward John KOWCUN
Defendant

REASONS FOR JUDGMENT

(Delivered 21 December 2017)

CHIEF JUDGE LOWNDES:

INTRODUCTION

1. The defendant was charged with various offences: assaulting a police officer whilst in the execution of his duty, resisting a member of the police force in the execution of his duty and engaging in offensive conduct. The defendant subsequently sought to have the charges dismissed pursuant to s 77(4) of the *Mental Health and Related Services Act* (the Act), which provides for a statutory defence of mental impairment.

2. The dismissal process is instigated by the court requesting from the Chief Health Officer a certificate stating:[1]

   (a) whether at the time of carrying out the conduct constituting the alleged offence, the person was suffering from a mental illness or a mental disturbance; and

[1] Section 77(2)(a) and (b).

(b) if the person was suffering from a mental illness or mental disturbance – whether the mental illness or mental disturbance is likely to have materially contributed to the conduct.

3. After receiving the certificate, the court must dismiss the subject charge or charges if satisfied that at the time of carrying out the conduct constituting the alleged offence:

(a) the person was suffering from a mental illness or mental disturbance;[2] and

(b) as a consequence of the mental illness or mental disturbance, the person:[3]

(i) did not know the nature and quality of the conduct; or

(ii) did not know the conduct was wrong; or

(iii) was not able to control his or her actions.

4. In accordance with s 77(2) and (4) of the Act a certificate was provided by the Chief Health Officer which stated that although at the time of the alleged offending the defendant was suffering from a mental illness, the mental illness did not materially contribute to the conduct constituting the alleged offence.

5. The report upon which the certificate was based was prepared by Ms Fiona Towns. Both the prosecution and defence sought to rely upon Ms Town's report.

6. Two expert reports were obtained by the defendant from Dr Walton, which were to the effect that at the time of the alleged offending the defendant was suffering from a self-induced psychosis, which materially contributed to the

[2] Section 7(4)(a).
[3] Section 7(4)(b).

offending.[4] The defendant relied upon those two reports which were tendered at the hearing of the s 77 application, at which Dr Walton also gave oral evidence.

THE ISSUES RAISED AT THE HEARING

7. Three main issues were raised at the hearing. They were:

   1. Can a substance induced mental illness form the basis for a dismissal under s 77 of the Act?

   2. What, if any, is the evidentiary weight of a s 77 certificate?

   3. Can the court be satisfied that a defence of mental impairment has been established under s 77 of the Act, thereby providing a basis for the dismissal of the charges?

THE SCHEME OF THE ACT

8. The first issue to be determined is whether a mental illness that is substance-induced can form the basis for a dismissal pursuant to s 77 of the Act.

9. This issue arose because Dr Walton was of the opinion that notwithstanding the defendant was suffering from a mental illness at the time of the alleged offending and that the illness materially contributed to the offending, the defendant could not avail himself of the s 77 defence of mental impairment because the mental illness from which the defendant as suffering was a drug–induced psychosis.

10. Whether or not a drug-induced mental illness can provide a basis for a dismissal under s 77 is a matter of statutory interpretation that can only be resolved by a close examination of s 77 read in conjunction with the whole of the Act, including the definition of "mental illness". Ultimately, it is a

[4]Exhibits D2 and D3.

matter of divining the legislative intent by taking the purposive approach to statutory interpretation as permitted by s 62A of the *Interpretation Act*.[5]

11. "Mental illness" is not defined in s 77 of the Act. However, it is defined in s 6(1) of the Act as:

> …a condition that seriously impairs. Either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory, and is characterised:
>
> (a) by the presence of at least one of the following symptoms:
> (i) delusions;
> (ii) hallucinations;
> (iii) serious disorders of the stream of thought;
> (iv) serious disorders of thought form;
> (v) serious disturbances of mood; or
>
> (b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least of one of the symptoms referred to in paragraph (a).

12. Section 6(2) of the Act goes on to provide that any diagnosis of mental illness is only to be made in accordance with internationally accepted standards.

13. The nature of a mental illness is further illuminated by the provisions of s 6(3) of the Act which provides a list of matters, the mere fact of which cannot be considered to be conclusive evidence or mental illness:

> A person is not to be considered to have a mental illness merely because he or she
>
> (a) expresses or refuses to express a particular political or religious opinion or belief, a particular philosophy or a particular sexual preference or sexual orientation; or
> (b) engages, or has engaged, in a particular political, religious or cultural activity; or

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[5]Section 62A provides:
"In interpreting a provision of an Act, a construction that promotes the purpose of object underlying the Act (whether the purpose or object is expressly stated in the Act or not) is to be preferred to a construction that does not promote the purpose or object".

(c) engages, or has engaged, in sexual promiscuity, immoral or illegal conduct or anti-social behaviour; or
(d) has a sexual disorder; or
(e) is intellectually disabled; or
(f) uses alcohol or other drugs; or
(g) has a personality disorder or a habit or impulse disorder; or
(h) has, or has not, a particular political, economic or social status; or
(i) communicates, or refuses to communicate, or behaves or refuses or fails to behave, in a manner consistent with his or her cultural beliefs, practices or mores; or
(j) is, or is not, a member of a particular cultural, racial or religious group; or
(k) is involved, or has been involved, in family or professional conflict; or
(l) has been treated for mental illness or has been detained in a hospital that provides treatment of mental illness; or
(m) has been admitted as an involuntary patient on the grounds of mental disturbance or complex cognitive impairment; or
(n) has acquired brain damage.

14. There is nothing in the Act's definition nor the provisions of ss 6(2) and (3) that precludes or imposes restrictions on a substance induced mental illness from being treated as a mental illness for the purposes of the Act.

15. There is no suggestion in the definition that a substance induced mental illness is not to be considered to be a mental illness. Furthermore, internationally accepted standards of mental illness do not preclude a substance induced mental illness from being treated as a mental illness. Finally, with due respect, I accept the following submission made by counsel for the defence:[6]

> [Section 6(3)] must be read in the context of the subsection 6(3) as a whole. The effect of this section is not to exclude any consideration of the matters listed from an assessment of whether the person suffers from a mental illness, but rather, as the section expressly provides, to prevent a conclusion of mental illness from their mere presence. This construction should be preferred because (a) of the use of the phrase "merely because", which has the ordinary meaning akin to "simply because" and (b) the provision must be construed consistently with its apparent purpose of protecting civil and

[6] [19] – [21] of the written submissions of the defendant.

political liberties from being diagnosed as indications of mental illness. For example, a person cannot be diagnosed with a mental illness merely because they are religious – but that does not prevent a psychiatrist from interpreting a person's preoccupation with themes of religious grandiosity as delusional and evidence of mental illness.

Relevantly to the present matter, s 6(3) states that a person is not to be considered to have a mental illness "merely because" they use alcohol or drugs. The defendant submits that, properly construed, the provision does not exclude a substance induced psychosis from being a mental illness. The provision, it is submitted, rather has its ordinary meaning – that the mere use of alcohol or drugs is not conclusive evidence of mental illness. This has the effect of excluding the use or the normal intoxicating effects of substances from being conclusive evidence of mental illness. The provision does not preclude, however, drug or alcohol use from being considered as part of the picture on which a diagnosis of mental illness is founded.

The provision has to be construed in light of its object and purpose. Some of the objects and purposes have been canvassed above, but importantly the *MHRSA*'s primary purpose is to provide for the psychiatric care and treatment of people with mental illness. Any concerns about the definition of mental illness being too broad are remedied by the requirement for any diagnosis to be made in accordance with internationally accepted clinical standards, which allows the *MHRSA* to provide a definition of mental illness that can adapt to developments and new knowledge in the psychiatric profession. The objects and purposes, it must be stressed, are not to narrowly confine the types of mental illness for which people can be involuntarily treated, for example, but to provide an adaptable framework of legislative powers to facilitate health professional's treatment of patients.

16. The definition of "mental illness" in s 6(1) of the Act and the complementary provisions of ss 6(2) and (3) have general application throughout the Act, and should be read as applying to the term "mental illness" wherever it appears in the Act, unless there is a clear indication that in a specific context the term should be attributed an alternative meaning. In the absence of a contrary indication, the reference to "mental illness" in s 77 of the Act is to be interpreted in light of s 6 of the Act. Accordingly, a substance induced mental illness is capable of forming the basis for a dismissal of charges pursuant to s 77 of the Act.

17. It is important to keep firmly in mind the purpose and function of s 77 of the Act. In effect, the section provides a defence of mental impairment in relation to criminal matters that are dealt with summarily in the Local Court. The section has no application to matters that are dealt with in the Supreme Court. Therefore, if an accused wishes to raise a defence of mental impairment in Supreme Court proceedings, the provisions of Part 11A of the *Criminal Code* apply.

18. Section 43C of the Code provides a defence of mental impairment which is similar in terms to the defence created by s 77 of the *MHRSA*.

19. Section 43C provides:

    1) The defence of mental impairment is established if the court finds that a person charged with an offence was, at the time of carrying out the conduct constituting the offence, suffering from a mental impairment and as a consequence of that impairment:

        (a) he or she did not know the nature and quality of the conduct;

        (b) he or she did not know that the conduct was wrong (that is he or she could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong); or

        (c) he or she was not able to control his or her actions.

    2) If the defence of mental impairment is established, the person must be found not guilty because of the mental impairment.

20. "Mental impairment" is defined as including a mental illness.[7] "Mental illness" is defined in s 43A of the Code as meaning:

[7] Section 43A of the Code.

> An underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to an extraordinary stimuli (although such a condition may be evidence of a mental illness if it involves some abnormality and is prone to recur).

21. The fact that this definition of mental illness may present some difficulties for an accused who seeks to rely upon a defence of mental impairment in circumstances where the mental illness is brought about, or given rise to, by voluntary intoxication in Part 11A proceedings in the Supreme Court is immaterial for present purposes.[8] That is so because the jurisdiction conferred by Part 11A of the Code is exclusively exercised by the Supreme Court; and the provisions of that Part, including the definition of "mental illness", have no application in relation to proceedings brought under s 77 of the *Mental Health and Related Services Act* – which are within the exclusive jurisdiction of the Local Court.

22. For all of the foregoing reasons, the availability of a defence of mental impairment under s 77 of the Act is largely governed by the definition of "mental illness" in s 3 of that Act; and that definition is sufficiently broad to allow for a defence based on a substance induced mental illness, without any qualifications.

THE PURPOSE AND EFFECT OF THE SECTION 77 CERTIFICATE AND THE QUESTION OF WEIGHT

23. Section 77(2) of the Act requires the Chief Health Officer to provide a certificate stating:

    (a) whether at the time of carrying out the conduct constituting the alleged offence, the person was suffering from a mental illness or mental disturbance; and

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[8] There remains the vexed area of distinguishing between temporary states of mental impairment induced by intoxication (without there being an underlying pathological condition) and underlying diseases of the mind albeit caused by intoxication.

(b) if the person was suffering from a mental illness or mental disturbance – whether the mental illness or mental disturbance is likely to have materially contributed to the conduct.[9]

24. The s 77 certificate that issued in this case stated that notwithstanding the defendant was suffering from a mental illness at the time of the alleged offending, that mental illness did not materially contribute to the offending.

25. The purpose and effect of a s 77 certificate and its evidentiary weight was discussed at length in *O'Neill v Lockeyer* [2012] NTSC 10.

26. In that case Barr J held that the court could not rely on the certificate alone, without further evidence for a number of reasons:[10]

(a) The statements made by the Chief Health Officer in the certificate are necessarily based on opinion: the opinion of the Chief Health Officer, informed by the advice (factual details and opinion) of an "authorised psychiatric practitioner or designated mental health practitioner" under s 77(3);

(b) The opinion of the Chief Health Officer may be an expert opinion actually reached by the Chief Health Officer himself or herself, or may be a simple transmission of the opinion of another person, that is, of the psychiatric practitioner or mental health practitioner who provided the advice under s 77(3);

(c) The opinion of the Chief Health Officer may be a combination of both;

(d) The court should not rely exclusively on a s 77(2) certificate for the purpose of satisfying itself under s 77(4) that "at the time of carrying out

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[9] As pointed out by Barr J in *O'Neill v Lockeyer* [2012] NTSC 10, p7, s 77(2)(b) requires that the Chief Health Officer simply be satisfied on advice that there is a causal link between the mental illness of mental disturbance. Barr J further stated (p 8) that "a useful test as to whether a mental illness or mental disturbance materially contributed to conduct constituting the alleged offence is whether the mental illness or mental disturbance was a factor that operated actively to bring about the conduct".
[10] *O'Neill v Lockeyer* [2012] NTSC 10 pp 6-7.

the conduct constituting the alleged offence the person was suffering from a mental illness or disturbance";

(e) In many cases the court ought not to rely at all on a s 77(2) certificate for the purpose of satisfying itself under s 77(4)(a). The certificate may not be admissible in evidence, and even if admissible the weight to be accorded to it may be nil or slight;

(f) The certificate is not binding on the court, and the court must consider all the evidence;[11]

(g) An examination by the court of the evidence will reveal the basis on which the Chief Health Officer made the statements in the certificate. If they represent an expert opinion actually reached by the Chief Health Officer himself or herself; or if, on the evidence, the facts on which the expert opinion is based are established, then the statements of opinion would probably be admissible and entitled to such weight as the court thinks fit. If the statements in the certificate are merely a transmission of the opinion of another person, then the certificate will be inadmissible for the purposes of the court's consideration of the s 77(4) matters, and would in any event have little evidentiary weight.

27. Barr J went on to say that the court should always "go behind the certificate".[12] His Honour then stated:[13]

> Whether the court should receive as evidence the report on which the Chief Health Officer has relied is a separate question, to be answered by the court by reference to relevance and admissibility, as well as the principles relating to the receipt of expert evidence.

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[11]See *Mununggurr v Gordon & Anor, Mununggurr v Balchin & Anor* [2011] NTSC 82 at [19] and [20] where Kelly J said in relation to s 77(4)(a):

> "…the Court must undertake its own assessment of those matters, which it can only do by considering relevant evidence…the subsection plainly requires the Court to be satisfied of the relevant matters; it does not require, or authorise, the Court to accept the certificate of the Chief Health Officer as determinative of those questions."

[12]*O'Neill v Lockeyer* [2012] NTSC 10, p9.

[13]*O'Neill v Lockeyer* [2012] NTSC 10, p9.

28. His Honour concluded that the court's power to dismiss charges pursuant to s 77(4) of the Act was not entirely dependent on an initial establishment of the causal link between the defendant's mental state and the conduct in question through the s 77 certificate:[14]

> The court's power to dismiss charges pursuant to s 77(4) can only be exercised after the court has received a certificate from the Chief Medical Officer requested by the court under s 77(2)…
>
> …notwithstanding the requirement that the court first receive a certificate from the Chief Health Officer before proceeding under s 77(4), the court's power to dismiss charges pursuant to s 77(4) is not dependent on the establishment of the causal link, via the s 77 certificate, between the defendant's mental state and the conduct in question.

29. Barr J went to define the subsequent adjudicative role of the court:[15]

> The court has an independent role to consider and assess the evidence in any criminal proceeding where it is exercising summary jurisdiction. The court hears the evidence in chief and cross-examination of all prosecution and defence witnesses (including possibly the defendant). It therefore follows that the court's findings and conclusions may be different from the matters stated by the Chief Health Officer in the s 77(2) certificate. So, for example, even if the certificate of the Chief Health Officer certifies in the negative to the issue in s 77(2)(a), or in the affirmative to the issue in s 77(2)(a) but in the negative in s 77(2)(b),[16] the court might well arrive at an opposite conclusion after considering the identical issue to s 77(2)(a) as part of its s 77(4)(a) deliberations and may make findings under s 77(4)(b) inconsistent with the certificate of the Chief Health Officer under s 77(2)(b).

THE BURDEN AND STANDARD OF PROOF

30. It is clear from *O'Neill v Lockeyer* that the defendant bears the onus of satisfying the court that there is a proper basis for dismissing the charges.[17] The defendant carries the burden of satisfying the matters set out in

[14]*O'Neill v Lockeyer* [2012] NTSC 10, p10.
[15]*O'Neill v Lockeyer* [2012] NTSC 10, pp 10-11.
[16]This was the case with the certificate in the present proceedings.
[17]*O'Neill v Lockeyer* [2012] NTSC 10, p10.

s 77(4)(a) and (b) of the Act.[18] The relevant standard of proof is the "balance of probabilities".[19]

EXPERT OPINION EVIDENCE

31. As the defendant sought to rely upon the two reports obtained from Dr Walton, as well as the oral evidence he gave at the hearing of the s 77 by way of discharging the onus of proof, it is necessary to consider:

    (a) the admissibility of the witness' documentary and oral evidence; and

    (b) the weight to be given to that evidence once it has been found to be admissible.

32. The admissibility of expert opinion evidence is governed by s 79 of the *Evidence (National Uniform Legislation) Act* (NT):

    > If a person has specialised knowledge based on the training, study or experience, the opinion rule does not apply to evidence of an opinion of that person that is wholly or substantially based on that knowledge.

33. The effect of this section is that the opinion evidence of a witness is only admissible if the witness has by virtue of his or her training, study or experience specialised knowledge; and the opinion expressed by the witness is wholly or substantially based on that knowledge.

34. The preconditions to admissibility of expert opinion evidence under s 79(1) of the *Uniform Evidence Act* were considered by the High Court in *Dasreef Pty Ltd v Hawchar* (2011) 243 CLR 588. The majority identified the following pre-conditions:

    1) The fact in issue which the opinion is sought to prove must be identified. Put another way the opinion evidence must be relevant.[20]

[18] *O'Neill v Lockeyer* [2012] NTSC 10, p14.
[19] *O'Neill v Lockeyer* [2012] NTSC 10, p12 and 14.

2) The expert witness must have specialised knowledge based on his training, study or experience.[21]

3) The opinion must be wholly or substantially based on that knowledge.[22]

4) As a general rule, the "statement of reasoning" rule must be complied with:[23]

> …it is ordinarily the case, as Heydon JA said in *Makita* that "the expert's evidence must explain how the field of specialised knowledge in which the witness is expert by reason of training, study or experience, and on which the opinion is wholly or substantially based, applies to the facts assumed or observed so as to produce the opinion propounded.

35. The majority did not consider compliance with either the "assumption identification" rule or the "proof of assumption" rule a precondition for admissibility. Heydon J held that in order to be admissible expert opinion evidence has to satisfy both rules.[24]

36. The former requires the expert to disclose the facts and assumptions on which the expert's opinion is founded.[25] The latter requires the stated facts and assumptions to be proved.[26] This rule is often referred to as the "basis" rule.[27]

37. It follows from the majority decision in *Dasreef* that "if the opinion evidence is to be admitted, assessment of the weight to be given to the opinion will necessarily require consideration whether any facts assumed to have existed for the opinion have been proved to exist".[28] In other words, a

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[20](2011) 243 CLR 588 at [31].
[21](2011) 243 CLR 588 at [32].
[22](2011) 243 CLR 588 at [32].
[23](2011) 243 CLR 588 at [37].
[24](2011) 243 CLR 588 at [61], [64] and [66].
[25](2011) 243 CLR 588 at [61].
[26](2011) 243 CLR 588 at [61].
[27](2011) 243 CLR 588 at [61].
[28]S. Odgers *Uniform Evidence Law* 11th edition at [1.3.4320].

failure to prove the facts underlying the opinion goes to the probative weight of the evidence.

EVALUATION OF THE EXPERT OPINION EVIDENCE

38. In my opinion, the expert evidence contained in Dr Walton's two reports and the oral evidence he gave at the hearing satisfied the pre-conditions for admissibility as discussed by the majority in *Dasreef*, and therefore was admissible. However, the probative weight to be given to Dr Walton's evidence remains to be determined. The probative value of his evidence depends largely upon whether the factual substratum for his opinion has been established to the satisfaction of the court and whether the proven factual bases validly support the opinion proffered by Dr Walton.

39. In his initial report, Dr Walton stated that he examined the defendant on 15 February 2017. He mentioned that he had been provided with copies of the charges, the statement of facts, witness statements and the defendant's prior criminal history, as well as correspondence from Ms C Lightowler, community support worker, Banyan House and Ms S Abraham, Alcohol and Other Drugs Clinician, Banyan House, the report of Ms F Towns, social worker and the s 77 certificate from the Chief Health Officer, as well as the discharge summary from Cowdy Ward. The doctor also stated that he had spoken to the defendant's mother.

40. Dr Walton noted in his report that the defendant was admitted to Cowdy Ward on 3 August 2016 (some 11 days after the alleged offending) and discharged on 19 August 2016. He also stated that it was documented that the defendant had presented himself to the Royal Darwin Hospital Emergency Department on 28 July 2016 (5 days after the alleged offending), at which time he was considered to be in a state of "early relapse of psychosis". However, he was not admitted because he was not considered to be at risk. Dr Walton went on to report:

> By the time he underwent more extensive assessment preceding the admission to hospital, he was exhibiting clear cut auditory hallucinations and paranoid and religious delusions. He was diagnosed with schizophrenia. The history of substance abuse was noted.

41. In preparing his report, Dr Walton noted the observations made by Constable George Ciolka in his statutory declaration dated 23 July 2013 concerning the incident that gave rise to the laying of the charges against the defendant.[29] Those observations were that the defendant was "acting in an erratic manner by the way he was pacing and there was spittle coming from his mouth and I could see that his eyes were bloodshot".

42. Dr Walton also noted the observations made by Constable P Annakin which were to the effect that the defendant was intoxicated, and was using abusive language as well as being unco-operative.[30] He also noted the observations made by the defendant's wife which were to the effect that the defendant became agitated and was laughing and talking to himself, with his voice becoming louder.[31] He further noted the following narrative given by the wife: "I came outside and tried to calm the situation as the yelling was getting worse. He was talking to a person who was not present and swearing". Dr Walton also reported that the defendant was not aggressive towards her.

43. Dr Walton then dealt with the central part of his report – namely the history given to him by the defendant:

> Mr Kowcun stated that on the day in question "I was fighting with my clothesline" as he now recognises it. He stated that at the time "I thought it was a bat creature, the devil". This included his throwing objects in order to try and disperse the demonic figure and "I was chasing at shadows".

[29]See Exhibit P4.
[30]See Exhibit P4.
[31]See Exhibit P4.

Mr Kowcun stated that once police arrived he questioned them "did you catch him? And he stated that the physical contact with the police occurred because "I was trying to get rid of the bat".

He stated that throughout the period he was being assailed by auditory hallucinations making derogatory comments about him.

Mr Kowcun recognised that his mental state was deteriorating and he had presented himself to the psychiatric staff at the hospital but "they wouldn't accept me".

As he reflects upon the incident now he stated "I feel pretty babyish", which is a comment that he feels foolish that his sense of reality was so distorted at the time.

44. As regards to the medical history Dr Walton documented the following:

(a) the defendant has a psychiatric history dating back to 2006 when he was admitted with what he termed a "church psychosis" based on religious delusions with suicidal ideation;

(b) the defendant next came to psychiatric attention in January 2016 when he presented himself to the hospital emergency department due to depression and paranoia in the context of methamphetamine use;

(c) the defendant next presented on 27 July 2016, expressing suicidal thoughts and suffering from auditory hallucinations; and he was discharged in the early hours of the following morning;

(d) he subsequently presented himself to the Tamarind Centre, but it was not until 3 August 2016 that he was readmitted to hospital.

45. Dr Walton stated in his report that the defendant continues to attend the Tamarind Centre on a monthly basis, receiving long acting antipsychotic medication. As a result the defendant's previous paranoia and hallucinations have subsided.

46. Finally, as part of the defendant's history Dr Walton noted that he had a long history of alcohol/substance abuse; and on the day of the incident had

used cannabis and consumed a bottle of rum. Following the incident, the defendant underwent 3 months of rehabilitation at Banyan House and has since been alcohol and drug free.

47. After recording the defendant's personal history, Dr Walton evaluated the defendant's current mental state, noting that he was not thought disordered and exhibiting no signs of current psychosis.

48. Dr Walton then proceeded to proffer his expert opinion, which may be summarised as follows:

    (a) according to the documentation the defendant was regarded as suffering from schizophrenia aggravated by substance abuse rather than a simple drug-induced psychosis at the time of his last admission;[32]

    (b) albeit infrequent, the defendant is prone to psychotic breakdowns;

    (c) the fact that the defendant has been established on long acting injectable antipsychotic medication is consistent with him having been diagnosed with schizophrenia, but otherwise his history is more consistent with recurring drug induced psychoses;

    (d) the two diagnoses are mutually exclusive: he either suffers from substance-induced psychoses or from schizophrenia aggravated by substance abuse;

    (e) the preferred diagnosis is that of a drug induced psychosis;

    (f) substantially relying upon his account but to some extent the observations of others at the material time, the defendant seems to have been "in the grips of a psychotic episode" at the time and would seem to "provide the explanation for his rather bizarre behaviour";

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[32] Dr Walton noted that Ms Towns stated in her report that the defendant had been diagnosed with both conditions.

(g) accordingly, the defendant was mentally ill at the material time and his mental condition made a material contribution to the conduct constituting the alleged offending;

(h) given his history of abuse of alcohol and methamphetamine particularly the defendant is properly described as a substance-dependent person;

49. In his second report, Dr Walton noted the observations of the unidentified court clinician in the report of 25 August 2016 wherein it was concluded that "Mr Kowcun does warrant a section 77 of the Mental Health and Related Services Act Court Report". He goes on to note that Ms Towns stated that when the defendant was assessed by a nurse at the Darwin watch-house following the incident "there is no indication from the case records that he was suffering from mental illness or a drug-induced psychosis"; although it was noted that the defendant was unable to provide any information about the incident because of his lack of memory due to intoxication.

50. Dr Walton went on to say:

> It is conceded by Ms Towns that "whilst it was not likely to have materially contributed to the conduct, it is also likely that his mental state was deteriorating around the time of the index offence. The evidence for this being his presentation with the symptoms of a psychosis during the assessment at the Darwin Local Court on 25 August 2016, his subsequent admission to Cowdy Ward on 3 August 2016 with a further episode of drug-induced psychosis and diagnosis of schizophrenia and his ongoing need for treatment with antipsychotic medication.

51. Dr Walton stated that the conclusion was that the defendant was suffering from a recognised mental illness or mental disturbance at the time of the alleged offending, but Ms Towns believed that this "was not likely to have materially contributed to the conduct". The doctor went on to observe:

> It would seem that Ms Towns concedes that Mr Kowcun may have been sliding into a more advanced state of psychosis at the time of

the offending but ultimately she concluded that the mental disturbance did not make a material contribution.

52. Taking a different view, Dr Walton said:

> With respect, I believe that Ms Towns may not have placed sufficient weight, say, on the observations of Mr Kowcun's wife, a woman who was obviously thoroughly familiar with his behaviour when well or ill and she concluded that he was hallucinating at the time.
>
> Mr Kowcun's account to me would also suggest that he was actively psychotic, doing battle with a clothesline because of the delusional belief that it was a demonic bat.
>
> Thus I see no particular reason to change my view that Mr Kowcun was in a rather more disturbed frame of mind than seems to have been the impression of Ms Towns and I believe that he was in the grips of an active drug-induced psychosis at the material time. I remain of the view that this disturbed mental state of psychotic proportions is directly reflected in the bizarre behaviour which was part of the alleged offending and my view is that the situation certainly amounted to more than acute intoxication.
>
> I would certainly concede that it could not be opined unequivocally that Mr Kowcun's offending was the direct product of his psychosis at the time but I believe there are sound grounds for concluding that there was a material contribution to the misconduct. Over and above any compromised mental state attributable to acute intoxication, the psychotic symptoms are likely to have seriously compromised Mr Kowcun's ability to accurately perceive his circumstances at the time, his deluded ideas would have interrupted thinking processes ,and adversely affected his ability to contain behaviour which otherwise might have inhibited his ability to exercise proper social judgment.

53. The factual bases upon which Dr Walton formed the opinions expressed in his two reports were disclosed in both reports.

54. In relation to Dr Walton's first report, the factual bases upon which he formed his opinion that the defendant at the material time was suffering from a mental illness were:

1) the history given by the defendant;

2) the defendant’s documented psychiatric history; and

3) the observations made by certain individuals at, or proximate, to the time of the alleged offending.

55. With respect to Dr Walton’s second report, the factual bases upon which he concluded that the defendant was suffering from a mental illness at the time of the alleged offending were:

1) Ms Town’s conclusion that the defendant was suffering from a mental illness at the material time;

2) the observations of the defendant’s wife at the material time, in particular her conclusion that the defendant was hallucinating at the time of the alleged offending;

3) the defendant’s account suggesting that he was actively psychotic at the material time – doing battle with a clothesline due to his delusional belief that it was a demonic bat; and

4) the bizarre behaviour of the defendant that directly reflected his disturbed mental state of psychotic proportions.

56. As stated earlier, the weight to be given to Dr Walton’s opinion evidence depends upon whether the factual substratum for his opinion or opinions has been established to the satisfaction of the court and whether the proven facts validly support the opinion or opinions proffered by Dr Walton.

57. One of the mainstays of Dr Walton’s first report was the history given by the defendant which the doctor heavily relied upon in reaching his conclusion that the defendant was suffering from a self-induced psychosis at the material time, which materially contributed to the alleged offending.

58. Self – reporting, in terms of a history provided by a person to a medical practitioner, can be problematic. A fundamental concern with self –reporting

is that it is difficult to assess the accuracy or veracity of the history that is provided.

59. The accuracy of self – reporting depends upon the memory of the person providing the history. Memories, by their very nature, are imperfect and susceptible to distortion. They are notoriously faulty. Often a memory of an incident or event is a mixture of fact and fiction – it not always being possible to separate one from the other. Furthermore, memories can alter or fade over time.

60. The accuracy or veracity of self-reporting can only be assessed by examining other sources of information and the existence of any other evidence that may tend to corroborate or refute the person's account.

61. In the present case the defendant provided an account of the incident some 6 months afterwards in circumstances where he previously had no memory at all of the incident. Dr Walton used that account as a significant plank for his opinion that at the material time the defendant was suffering from a mental illness.

62. There are obvious concerns about the accuracy or veracity of the history given by the defendant to Dr Walton.

63. Although Dr Walton attempted to explain how it was possible for the defendant to have a memory of an incident which he previously had no memory of at all,[33] I found the explanation to be unconvincing. There is a very real possibility that the defendant's recollection is a complete fabrication. It is equally a very real possibility that the defendant has confused his recollection with his memory of a completely different incident, forming part of a psychotic episode connected with his subsequent admission to Cowdy Ward.

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[33]Page 22 of the transcript.

64. Furthermore, there is very little to corroborate and verify the defendant's belated recollection that he was fighting the clothesline due to his delusional belief that it was a demonic bat. The wife's evidence that the defendant was talking to himself and to a person who was not present - and was swearing - falls far short of the corroboration and verification that the court would require if it were to accept the history the defendant gave to Dr Walton as being a reliable and credible history. Despite the conclusion drawn by Dr Walton, at no stage did the wife say that the defendant was hallucinating. Her observations concerning the presentation and behaviour of the defendant were entirely consistent with the presentation and behaviour of a person in a state of acute intoxication.

65. Although the factual substratum for Dr Walton's opinion – namely that the defendant gave an account of a psychotic episode at the time of the alleged offending – has been established, the account given by the defendant six months after the alleged incident is so inherently unreliable that it is not capable of providing a sound basis for the doctor's opinion that the defendant was suffering from a drug-induced psychosis which made a material contribution to the offending.

66. Dr Walton also relied upon the defendant's psychiatric history, both before and after the incident giving rise to the alleged offending, as one of the factual bases for his opinion that the defendant was suffering from a mental illness at the material time.

67. However, it cannot be inferred to the reasonable satisfaction of the court from the fact that the defendant had been diagnosed with a mental illness in the past (circa 2006) and admitted to Cowdy Ward for a mental illness shortly after the incident that he was suffering from a mental illness at the time of the alleged offending.

68. Consistent with the statements made by Dixon J in *R v Porter*,[34] s 77 is only interested in the person's mental state at the time of the alleged offending (being the fact in issue), not with his subsequent mental state or what his previous state of mind was. A person may have been suffering from a mental illness before or after the alleged offending, but the crucial question is whether the person was suffering from a mental illness at the time of the alleged offending.

69. It is well recognised that in the case of mentally ill persons their mental illness can ebb and flow, as well as fluctuate. Furthermore, where the mentally ill person is also substance dependant, it is often very difficult to determine whether at a given time the person is suffering from a substance induced mental illness or merely from the effects of substance misuse. That is very much a live issue in the present case.

70. For these reasons, Dr Walton's reliance on the defendant's psychiatric history cannot provide a sound basis for his opinion that the defendant was suffering from a mental illness at the material time, in the absence of any other probative evidence.

71. Dr Walton also relied upon the observations of the defendant's wife in relation to the presentation and behaviour of the defendant, just prior to the incident giving rise to the alleged offending, as a basis for his expert opinion.

72. Her observations are confined to the defendant speaking to himself or a non – existent person, as well as swearing. Contrary to Dr Walton's view, the wife did not say that the defendant was hallucinating. The evidence clearly shows that the defendant was severely intoxicated at the material time, and the wife's observations are entirely consistent with a person suffering from the effects of acute intoxication.

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[34](1933) 55 CLR 182, 187.

73. The observations of the two police officers are also entirely consistent with a person suffering from the effects of acute intoxication.

74. Moreover, the weight to be attached to the opinion evidence expressed in Dr Walton's initial report is also affected by the observations of the nurse who examined the defendant at the police station following the incident. Significantly, the nurse found no signs of mental illness.

75. Turning to his second report, Dr Walton relied upon Ms Town's conclusion that the defendant was suffering from a mental illness at the material time – though noting her concomitant finding that the mental illness did not materially contribute to the conduct constituting the alleged offending.

76. In my opinion, the basis for Ms Town's conclusion that the defendant was suffering from a mental illness was tenuous.

77. In her report dated 28 August 2016 Ms Towns stated that the defendant had told her that he had no memory of the incident that resulted in the laying of the charges and that he was highly intoxicated at the time. He also stated that he thought he had been fighting with a clothesline at the time. He added that he had no memory of events and that the first he knew of the charges was when he woke up in police custody.

78. In her further report (prepared for the purposes of the s 77 certificate) dated 8 November 2016 Ms Towns noted that PCIS records indicated that the defendant was assessed by a nurse at Darwin Watch House on 23 July 2016 (the day of the alleged offending). The defendant was noted to be argumentative and he reported that he consumed alcohol and smoked cannabis earlier that day. Ms Towns noted that there was no information in the PCIS notes from the time of his assessment to suggest that the defendant was suffering from any drug or alcohol induced psychosis.

79. Ms Towns noted that the defendant repeated to her that he had no memory of events, but thought that he was fighting with a clothesline at the time of the alleged offending.

80. Ms Towns further stated in her report that during the mental state examination performed on 25 August 2016 the defendant‘s “thought content included paranoid/religious delusional themes including being able to predict what will happen and recurrent thoughts about the devil”. However, she noted that he denied any current auditory or visual hallucinations and he was not observed to be responding to internal stimuli.

81. After noting that there was no indication from the case records relating to his assessment at the Darwin Watch House (on the day of the alleged offending) that the defendant was suffering from a mental illness or a drug induced psychosis, that he was intoxicated due to alcohol consumption and that had no memory of the events in question, Ms Towns formed the following opinion:

> Whilst it was not likely to have materially contributed to the conduct, it is likely that his mental health was deteriorating around the time of the index offence. The evidence for this being his presentation with symptoms of psychosis during the assessment at Darwin Local Court on 25 August 2016, his subsequent admission to Cowdy Ward on 3 August 2016 with a further episode of drug induced psychosis and diagnosis of schizophrenia and his ongoing treatment with antipsychotic medication.

82. Ms Towns then proceeded to conclude that pursuant to s 77(2)(a) of the *Mental Health and Related Services Act* the defendant was suffering from a mental illness or mental disturbance at the time of the alleged offences; though that mental illness or mental disturbance was not likely to have materially contributed to the conduct.

83. With due respect to the court clinician, her conclusion that the defendant was suffering from a mental illness at the material time was not supported by the whole of the evidence.

84. The subsequent presentation with psychotic symptoms and the admission to Cowdy Ward does not prove that the defendant was suffering from a mental illness at the material time, particularly given that the defendant was heavily intoxicated at the time. The observation that it was likely that the defendant's mental health was "deteriorating around the time of the index offence" falls far short of a finding that he was suffering from a recognised mental illness at the time. Finally, but not least, the absence of any signs of mental illness at the time the defendant was examined by the Watch House nurse is particularly telling, and militates against a finding that he was suffering from a mental illness at the time of the alleged offending.

85. It must follow that to the extent that Dr Walton relied upon Ms Town's conclusion the basis for his opinion is less than sound.

86. To the extent that Dr Walton again relied upon the defendant's wife's observations the doctor's opinion is less than sound for the reasons stated earlier.

87. Dr Walton's continuing reliance upon the defendant's account indicating that he was psychotic at the material time fails to provide a satisfactory foundation for his expert opinion for the reasons given earlier.

88. Finally, the statement made by Dr Walton to the effect that the bizarre behaviour of the defendant directly reflected his disturbed mental state of psychotic proportions adds nothing to the probative value of Dr Walton's evidence.

89. It is noteworthy that neither the first or second report of Dr Walton addressed – or adequately addressed - the statutory criteria prescribed by s 77(4)(b) of the Act.

90. It remains to consider the probative value of Dr Walton's oral evidence.

91. Dr Walton repeated his view that the defendant was suffering from a mental illness, the preferred diagnosis being a drug-induced psychosis. He repeated his view that the mental illness materially contributed to the defendant's conduct on the occasion in question, and proceeded to give the following evidence:[35]

> …it seemed to me that he was quite actively psychotic at the time and spoke about doing battle with a demonic bat, which was actually the clothesline, I think. His wife had noticed quite a change in his behaviour. He seemed to be conversing with – to non-existent people to her. Now, so the way that this might affect his thinking was, first of all, he was having distorted perceptions, he's out of touch with reality. He was under the effective deluded thinking so by definition he could not think clearly. He was exhibiting bizarre behaviour. It is highly likely with those sort of fairly serious psychiatric phenomena occurring that person would not be able to reason carefully or consider the consequences of their actions appropriate.

92. When asked the leading question - "and so it's your view, is it, as you've have just indicated that he was not able to reason with a moderate degree of sense and composure"- Dr Walton said "yes, yes, my view in fact he – bar for the fact that he had the type of illness which is precluded, he would have had a defence of mental impairment".[36]

93. As previously noted, Dr Walton based this opinion evidence on the history given by the defendant as well as the observations of the defendant's wife. As previously stated, neither of these factual substratum were sufficiently supportive of the opinion expressed by Dr Walton.

94. That aside, the opinion itself did not sufficiently address the statutory criteria prescribed by s 77(4)(b).

95. His response to the leading question suggests that he was leaning towards the criteria in s 77(4)(b)(ii) – namely that the defendant did not know the conduct was wrong. However, at no time did Dr Walton express the opinion

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[35]Page 3 of the transcript.
[36]Page 4 of the transcript.

that the defendant did not know the conduct was wrong. Nor did he address the legal test that is required to be met to satisfy that criteria, which is to the effect that the person "could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong".[37] It should be noted that there is no restriction on an expert witness addressing the ultimate issue in relation to an application under s 77 of the Act.[38]

96. Dr Walton stated that he had spoken to the defendant's mother and also had the wife's statement.[39] He said that he had not reached his diagnosis of a self-induced psychosis exclusively on the statement of the wife, but stated that her statements and observations were consistent with that diagnosis.[40]

97. Dr Walton also said that he had taken into account the observations and notes of the nurse who saw the defendant soon after the incident and who found no signs of drug or alcohol induced psychosis.[41] The doctor noted that the defendant had not disclosed to the nurse the history that the defendant had provided to him.[42] However, Dr Walton conceded the possibility that defendant may have lied to him in relation to the incident.[43]

98. Dr Walton did not appear to disagree with the proposition that nowhere in the statements of the three witnesses was there a reference to the defendant fighting with a clothesline.[44] However, he pointed out that the wife had mentioned that the defendant was talking to a person who was not present.[45]

99. Dr Walton agreed that people who are highly intoxicated may talk to themselves; but said that the defendant's case was distinguishable because

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[3737]This test is derived from the judgment of Dixon J in *R v Porter* (1933) 55 CLR 182 at 190 and has been consistently applied in subsequent authorities.
[38]Section 80 of the *Evidence (National Uniform Legislation) Act*.
[39]Page 9 of the transcript.
[40]Page 9 of the transcript.
[41]Page 11 of the transcript.
[42]Page 11 of the transcript.
[43]Page 11 of the transcript.
[44]Page 12 of the transcript.
[45]Page 12 of the transcript.

he had a history of psychosis.[46] The doctor went on to say that "talking to a person who is not present" is not typical of someone who's intoxicated, but it could happen.[47]

100. Dr Walton agreed that there was nothing in the statements of the two police officers that was inconsistent with "a man who was intoxicated and belligerent".[48] However, he said that the question is: "was it more than that?"[49]

101. Although Dr Walton agreed that the conduct of the defendant as observed by the police officers was certainly consistent with intoxication, he said that it did not exclude the fact that the defendant may also been psychotic at the time.[50] Dr Walton then went on to say that although a psychotic episode could not be excluded, there was nothing "positively supportive of that proposition" in the statement of Constable Annakin.[51]

102. Although Dr Walton agreed that there was nothing in the statements of the two police officers that was supportive of the fact that the defendant was suffering from a psychosis at the material time, he viewed the wife's statement as being "more consistent with someone having perceptual distortion".[52]

103. Dr Walton was taken to the preliminary report dated 25 August 2016 wherein the author noted that the defendant was highly intoxicated and had no memory of the incident, though he had said that "he thought he was fighting with a clothesline at the time". Dr Walton's response was that if the

[46]Page 12 of the transcript.
[47]Page 12 of the transcript.
[48]Page 12 of the transcript.
[49]Page 12 of the transcript.
[50]Page 15 of the transcript.
[51]Page 15 of the transcript.
[52]Page 15 of the transcript.

defendant had an alcohol blackout he would have no memory, including a memory of the "strange behaviour with the clothesline".[53]

104. It was put to Dr Walton that the defendant had gone from having a negative memory (at the time he was seen by the court clinician) to a positive memory of the incident (at the time he was examined by him). That positive memory included having physical contact with the police officer because he was "trying to get rid of the bat".[54] Dr Walton agreed that the defendant had not provided the court clinician with that information.[55] The doctor also agreed that the defendant had not mentioned to the court clinician a bat or devil or "chasing its shadows".[56] In fact, he agreed that the defendant had told the clinician that he had no memory of the incident.[57] Dr Walton accepted that the two histories were contradictory.[58]

105. Although Dr Walton accepted that the defendant had gone from "fighting with a clothesline to devils, bat creatures and the like", he thought that "fighting with a clothesline is fairly bizarre in and of itself".[59]

106. Dr Walton agreed that the defendant's presentation at the hospital on 28 July 2016 might be some evidence of mental illness, but not necessarily.[60]

107. Dr Walton told the court that he had not asked the defendant why it was that when he spoke to the court clinician he could not remember the matters he mentioned to him, -including his interaction with police on the evening of the incident.[61] Dr Walton's explanation was in these terms:[62]

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[53]Page 16 of the transcript.
[54]Page 17 of the transcript.
[55]Page 17 of the transcript.
[56]Page 17 of the transcript.
[57]Page 17 of the transcript.
[58]Page 17 of the transcript.
[59]Page 17 of the transcript.
[60]Page 18 of the transcript.
[61]Page 22 of the transcript.
[62]Page 22 of the transcript.

Well, it's not for me to determine the facts of the matter and I have stated what I relied on and that could be questioned. But I have documented the account he gave to me.

108. Dr Walton agreed that the account that he relied upon depended upon the honesty of that account and ability of the defendant to properly recall events.[63]

109. Dr Walton went on to say that although the defendant said that he could not remember, "that's not what he demonstrates".[64] He went on to say that "it's not uncommon for people who have been drunk to have a fuller recollection later on, when sober".[65]

110. Dr Walton's oral evidence adds little, if nothing, to the probative value of his expert opinion that the defendant was suffering from a mental illness at the material time and that the illness made a material contribution to the alleged offending. The bases upon which he formed his opinion do not support the opinion.

DECISION

111. In my opinion, the defendant has failed to satisfy the court on the balance of probabilities that at the time of carrying out the conduct constituting the alleged offences he was suffering from a mental illness and as a consequence of the mental illness he:

(a) did not know the nature and quality of the conduct; or

(b) did not know the conduct was wrong; or

(c) was not able to control his actions.

112. The factual substratum for Dr Walton's opinion that the defendant was suffering from a mental illness at the material time was either not

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[63] Page 22 of the transcript.
[64] Page 22 of the transcript.

established to the satisfaction of the court, or if established did not sufficiently support the opinion such that the court could be satisfied on the balance of probabilities that the defendant was at the time of carrying out the relevant conduct suffering from a mental illness.

113. Furthermore, even if the defendant had been found to have been suffering from a mental illness, the matters set out in s 77(4)(b) of the Act have not been proved to the reasonable satisfaction of the court.

114. The court therefore dismisses the application under s 77 of the Act.

Dated this 21 day of December 2017

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DR JOHN LOWNDES
CHIEF JUDGE

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[65] Page 22 of the transcript.