CITATION:	*Police v RNB* [2025] NTLC 14
PARTIES:	*Police*
	V
	RNB
TITLE OF COURT:	LOCAL COURT
JURISDICTION:	CRIMINAL
FILE NO(s):	22323472, 22323525 & 22323785
DELIVERED ON:	28 July 2025
DELIVERED AT:	Darwin
HEARING DATE(s):	12 February 2025
DECISION OF:	Judge Macdonald

CATCHWORDS:

MENTAL HEALTH - Application of section 77 of *Mental Health and Related Services Act 1998* - Interpretation - Definition of mental illness - Definition of mental disturbance - Moral culpability - Dismissal of charges

Mental Health and Related Services Act 1998 ss 4, 6, 14, 15, 77

Makita (Aust) Pty Ltd v Sprowles (2001) 52 NSWLR 705
Munungurr v Gordon & Ors [2011] NTSC 82
O'Neill v Lockyer [2012] NTSC 10
SZTAL v Minister for Immigration and Border Protection [2017] HCA 34

REPRESENTATION:

Counsel:

Police:	Mr B Fernandez
Defendant:	Mr J Bach

Solicitors:

Police:	ODPP
Defendant:	NTLAC

Decision category classification:	B
Decision ID number:	[2025] NTLC 14
Number of paragraphs:	34

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

No. 22323472, 22323525 and 22323785

BETWEEN:

Police

AND:

RNB

Defendant

REASONS FOR DECISION

(Delivered 28 July 2025)

JUDGE MACDONALD

Background

1. On 26 February 2025 I dismissed all charges against Defendant Ms RNB in these proceedings under s 77 of the *Mental Health and Related Service Act 1998* (NT) (MH&RS Act), with written reasons to be published. These are those reasons.

2. Proceedings 22323472, 22323525 and 22323785 charged Ms RNB with a total of 10 offences (Charges) alleged to have been committed by her at Galiwinku over a four-day period of 24, 25 and 27 July 2023. Those offences had a significant degree of commonality, in that they all involved features of violence, ranging across aggravated assault; hinder, resist and assault police; armed in public and with an offensive weapon; and damage property.[1] That behaviour appeared to be in an elevated and uncharacteristic state.

3. Ms RNB is a 45 year old Yolngu woman who has lived a traditional life at Galiwinku, including bringing up four children. She speaks at least three languages, and particularly Djambarrpuyngu.[2] Bar one conviction for damaging property in 2019, Ms RNB had no prior criminal history.[3] Until her medical issues escalated in 2022, Ms RNB had been employed cooking at the school canteen and cleaning houses around Galiwinku.[4]

4. It was common ground that RNB had not at any time during late July, or proximate to then, been admitted involuntarily to any approved treatment facility within the meaning of Part 6 of

[1] In contravention of various provisions of the *Criminal Code*, *Police Administration Act*, and *Bail Act*.

[2] For the complexities of this, see https://en.wikipedia.org/wiki/Dhuwal_language

[3] The details of that transgression were not the subject of evidence at hearing, the disposition of imprisonment imposed on determination in 2020 (albeit then suspended) indicates that incident of 22.9.2019 giving rise to the charge was a serious matter.

[4] Letter of Dr Krita Sridharan being part of PCIS record, dated 10 November 2022.

the MH&RS Act. Although that result is not an essential precondition to application of s 77, involuntary admission would certainly be a clarifying consideration. However, Ms RNB was, firstly, arrested and remanded following the last incident of the four day period of offending behaviour, on 27 July 2023. Secondly, she was under close medical scrutiny while on remand at DCC from late July 2023, and was so unwell for a period of days following arrest that she was incapable of providing informed instructions to her lawyer. Most relevantly, Ms RNB was then admitted to the Royal Darwin Hospital (RDH) on more than one occasion during August 2023 while an inmate of DCC on remand. That was in the context of a range of serious symptoms and possible causes referred to in some detail below, and extensively in the evidence heard and tendered on 12 February 2025. Ms RNB was ultimately discharged from the RDH Neurology Ward back to Galiwinku on 31 August 2023.

5. The Charges were first mentioned in September 2023, with a preliminary section 77 report being provided to the court on 3 October 2023. At hearing on 12 February 2025 Ms RNB's situation was the subject of a Form 37 signed by the Chief Health Officer under s 77 (Certificate), issued on 10 April 2024. That was following an extensive written opinion provided by Designated Mental Health Practitioner (DMHP) Ms Jarczyk on 3 April 2024 (Report).

The Law

6. The possibility of summary charges being dismissed in certain circumstances is found in s 77 of the MH&RS Act, which provides;

77 Dismissal of charge

> *(1) This section applies to a person if:*
>
> *(a) the person is charged with an offence in proceedings before a court (other than proceedings for a committal or preliminary hearing); and*
>
> *(b) the charge is being dealt with summarily.*
>
> *(2) The court may request from the Chief Health Officer a certificate in the approved form 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*
>
> *(b) if the person was suffering from a mental illness or mental disturbance – **whether the mental illness or disturbance is likely to have materially contributed to the conduct**.*
>
> *(3) The Chief Health Officer must not give the court the certificate unless the Chief Health Officer has received and considered advice on the person from an authorised psychiatric practitioner or designated mental health practitioner.*
>
> *(4) After receiving the certificate, the court **must dismiss** the charge **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**; **and***

*(b) **as a consequence** of the mental illness or disturbance, the person:*

*(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. (**emphasis** added)

7. The primary authorities concerning s 77 are *Mununggurr v Gordon & Ors* [2011] NTSC 82 and *O'Neill v Lockyer* [2012] NTSC 10. That includes that a defendant bears the onus of proof to the standard of balance of probability.[5] Various passages also highlight the distinctions between the role of a certificate issued under s 77 and the court's obligation to consider the whole of the evidence.[6]

8. Due to the objects, purpose and subject matter of s 77, a range of other provisions of the MH&RS Act have some relevance to its application. Interpretation and application of the MH&RS Act is governed by contemporary principles of statutory construction, including as set out in *SZTAL v Minister for Immigration and Border Protection* [2017] HCA 34 at [14] and [37] to [39]. Simply put, ascertaining the natural and ordinary meaning of any provision, while having due regard for the context and purpose of the Act. That includes a requirement to read the Act as a whole.

9. Section 6 relevantly defines "*mental illness*" as;

6 Mental illness

*(1) A **mental illness** is 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 one of the symptoms referred to in paragraph (a).

(2) A determination that a person has a mental illness is only to be made in accordance with internationally accepted clinical standards.

[5] *Lockyer* (supra) at pp 11 to 12.

[6] *Mununggurr* (supra) at [19] and [20] and *Lockyer* (supra) at pp6 to 9.

10. Notably, s 6(3) then expressly excludes a range of matters from consideration as evidence of "*mental illness*", simply by their presence in the presentation of a patient. Those include where the patient "*has been admitted as an involuntary patient on the grounds of mental disturbance or complex cognitive impairment*" or "*acquired brain damage*".[7] The latter two conditions do not enliven consideration under s 77.

11. Section 14 of the MH&RS Act then proceeds to prescribe the criteria for involuntary admission on the grounds of mental illness, with essential prerequisites including that without treatment, the patient "*is likely to cause serious harm*" to themselves or another, and "*is not capable of giving informed consent*" to treatment or has "*unreasonably refused*" to give such consent.[8] A rudimentary criterion for the application of s 14 is also that there must be "*no less restrictive means of ensuring that the person receives the treatment*".

12. Obviously if a patient can give informed consent and is willing to be voluntarily admitted, consideration of involuntary admission does not arise. It is unnecessary to detail the scheme for voluntary admission, except to say that the criteria for voluntary admission is centred on a medical practitioner being "*satisfied that the person is likely to benefit from being admitted*", and the "*best interests*" of the patient.[9] Unlike with involuntary admission, voluntary admission is not expressly conditioned on any of the trichotomy of "*mental illness*", "*mental disturbance*" or "*cognitive impairment*", each of which may provide a basis for involuntary admission.[10]

13. For reasons which are addressed below, the question of "*mental illness*" did not become a determinative issue in the proceeding. However, the provisions concerning mental illness are of some relevance, through the dichotomy of "*mental illness*" and "*mental disturbance*" contained in s 77 of the MH&RS Act.

14. Despite the comprehensive definition of "*mental illness*" provided by s 6 of the MH&RS Act, the concept of "*mental disturbance*" is not specifically defined, or is at best piecemeal.[11] Firstly, s 4 defines the analogous state of "*mentally disturbed*" to mean *"behaviour of a person that is so irrational as to justify the person being temporarily detained under this Act*".[12] However,

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[7] Paragraphs (p) and (q) of subsection 6(3) of the MH&RS Act.

[8] The concept of "*serious harm*" is not defined and must be taken to be lesser than the meaning of that phrase at criminal law.

[9] Sections 25 and 29 of the MH&RS Act.

[10] It may be noted that a fourth (sub) category appears to be recognised, being "*behavioural disturbance*". However, that condition is simply a criterion provided by s 6A of the MH&RS Act, which must first be satisfied in order to render any "*cognitive impairment*" to be a "*complex cognitive impairment*" such as to justify involuntary admission for that affliction. That is, a person has a "*behavioural disturbance"* if the person's "*mental condition has deteriorated to the extent the person is behaving in an aggressive manner or is engaging in seriously irresponsible conduct*".

[11] Similarly, each of "*behavioural disturbance*", "*cognitive impairment*" and "*complex cognitive impairment*" are defined in s 4, by reference to s 6A of the MH&RS Act.

[12] The difference between "*mental disturbance*" and "*mentally disturbed*" is explicable through the precursor to the current s 77 providing that the latter state was, along with the alternative of "*mental illness*", grounds upon which a summary charge might be dismissed. The 2008 amendments to the MH&RS Act through Act No. 8 of 2007 amended that state to "*mental disturbance*" without proceeding to amend the relevant definition. An internal *in pari materia* approach is warranted.

s 15 of the MH&RS Act then effectively provides context to what may comprise mental disturbance, as follows:

> ***15 Involuntary admission on grounds of mental disturbance***
>
> *The **criteria** for the **involuntary admission** of a person on the grounds of **mental disturbance** are that:*
>
> *(a) the person does not fulfil the criteria for involuntary admission on the grounds of mental illness or complex cognitive impairment; and*
>
> *(b) the person's **behaviour is, or within the immediately preceding 48 hours** has been, **so irrational as to lead to the conclusion** that:*
>
> *(i) the person is experiencing or exhibiting a **severe impairment of or deviation from his or her customary or everyday ability to reason and function in a socially acceptable and culturally appropriate manner; and***
>
> *(ii) the person is **behaving in an abnormally aggressive manner or is engaging in seriously irresponsible conduct that justify a determination that the person requires psychiatric assessment, treatment and care** that is available at an approved treatment facility; **and***
>
> *(c) **unless the person receives treatment and care** at an approved treatment facility, he or she:*
>
> *(i) is **likely to cause serious harm to himself or herself or to someone else**; **or***
>
> *(ii) **will represent a substantial danger to the general community; or***
>
> *(iii) **is likely to suffer serious mental or physical deterioration; and***
>
> *(d) **the person is not capable of giving informed consent** to the treatment and care or has unreasonably refused to consent to the treatment and care; **and***
>
> *(e) **there is no less restrictive means of ensuring that the person receives the treatment** and care.* (**emphasis** added)

15. It may be noticed that application of s 77 is not expressly conditioned on a defendant satisfying the criteria for involuntary admission, on the grounds of either "*mental illness*" or "*mental disturbance*". However, adopting and applying the definition of "*mentally disturbed*" to "*mental disturbance*", a finding of "*mental disturbance*" for the purpose of s 77 is conditioned on a determination that the defendant's behaviour "*is so irrational as to justify the person being temporarily detained*" under the MH&RS Act. The term "*temporarily detained*" is to be read as broader than but generally synonymous with "*involuntary admission*". Consequently, there can be no condition of "*mental disturbance*" unless and until a defendant's behaviour is so acute as to "*justify*" satisfaction of the criteria prescribed by s 15 of the MH&RS Act. The acuity of any defendant's presentation immediately prior to, during, and following any actions alleged to attract criminal liability is a pivotal consideration in s 77, having regard to the s 15 criteria.

16. Given the s 4 definition of "*mentally disturbed*" together with the criteria prescribed by s 15, central concepts to "*mental disturbance*" are marked 'irrationality', an 'inability to reason and function' to an acceptable and appropriate level, together with either 'aggressiveness' or 'seriously irresponsible conduct'. It is important to note that, in order to conclude a state of

"*mental disturbance*", each of those features must be present. That is, the features must be conjunctive or cumulative in the patient's presentation.

17. At hearing the Prosecution properly contended that s 6(2) must be kept in mind in interpreting and applying the MH&RS Act, including s 77. Section 6(2) provides that "*A determination that a person has a **mental illness** is only to be made in accordance with internationally accepted clinical standards*" (**emphasis** added).[13] Given the subject matter, purpose and clinical focus of the MH&RS Act, context would enable that approach in any event, however s 6(2) is of assistance in fortifying this.[14] It is not my conclusion that the location of the directive of s 6(2) within the definition of "*mental illness*" produces the result that "*internationally accepted clinical standards*" are irrelevant to other subject matter of the MH&RS Act.[15] The clinical focus of the MH&RS Act is much broader than simply s 6(2), and regulates (amongst others) the condition of "*mental disturbance*" to a necessary extent.[16]

18. However, the clinical focus and contrast between the two states to which s 77 expressly applies, being "*mental illness*" and "*mental disturbance*" is marked. That is despite that those states appear in the MH&RS Act in conjunction with each other on more than 30 occasions. By way of contrast, "*mental illness*" and "*mental disturbance*" are referred to on 16 and 3 occasions respectively, in DSM-5.[17] It may also be relevant that those three references to "*mental disturbance*" are all in the context of side effects of drugs.

19. Crucial to determination of the primary issue in the proceedings is the meaning of "*mental disturbance*". It might be concluded that the conceptual similarity between "*behavioural disturbance*" as defined in s 6A(3) and "*mental disturbance*" in s 77 results in the former condition providing some colour to the meaning of the latter. The condition of "*behavioural disturbance*" is defined by s 6A(3) to be "*A person has a **behavioural disturbance** if the person's mental condition has deteriorated to the extent the person is behaving in an aggressive manner or is engaging in seriously irresponsible conduct*". A presentation involving 'aggression' and 'seriously irresponsible conduct' is required as an integral indicia to the separate basis of involuntary admission, being "*complex cognitive impairment*". As "*behavioural disturbance*" is simply one component of the qualifying criteria required to make out "*complex cognitive impairment*", the commonality is probably of no consequence.

20. Regardless, reference to "*mental disturbance*" in s 77 of the MH&RS Act in conjunction with "*mental illness*" suggests a composite approach in Parliament's intent, at least to the extent of the consequences for the defendant's insight at the time of the behaviour, as provided by

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[13] Although the source of clinical standards is manifold, an accepted starting point would be the *Diagnostic and Statistical Manual of Mental Disorders 5th Edition* (DSM-5), published by American Psychiatric Association, Arlington, VA, 2013.

[14] See ss 3, 4, 8 and 9 to 13 of the MH&RS Act. The offices of "*authorised psychiatric practitioner*" and "*designated mental health practitioner*" appointed through sections 22 and 23 are also pivotal designations to the operation and application of the MH&RS Act.

[15] Particularly situations involving "*mental disturbance*" and "*complex cognitive impairment*"; see Part 2 and Divisions 3 and 4 of Part 6 of the MH&RS Act.

[16] As noted above, 'mental disturbance' at a level not justifying a person being "*temporarily detained*" having regard to the s 15 criteria does not amount to "*mental disturbance*" for the purposes of the MH&RS Act.

[17] It is also noted that "*mental disorder*", "*behavioural disturbance*" and "*cognitive impairment*" are referred to on 1212, 187 and 79 occasions, respectively.

s 77(4). Clearly each condition also entails a cerebral component, through the term 'mental'. Due to the relevance of brain function to all behaviour other than automatism, that observation is perhaps of little assistance.

21. It may also be noticed that the provisions of ss 3 and 8 of the MH&RS Act, *Objects* and *Interpretation of Act*, expressly refer to "*mental illness*", but not "*mental disturbance*" or "*complex cognitive impairment*".[18] That is not to say that those provisions have no application to the latter two conditions (and their omission may simply be an artefact of the broadening of the MH&RS Act over time). However, a predominant focus of many provisions of the MH&RS Act is "*mental illness*".

22. The coercive provisions of the MH&RS Act treat the conditions of mental illness, mental disturbance and complex cognitive impairment as separate and discrete conditions. This includes by providing particular provisions for involuntary admissions which are specifically directed to each condition.[19]

23. Consideration of the definitions and concepts provided by the MH&RS Act lead to a conclusion that the definition or identification of the qualifying criterion of "*mental disturbance*" is rooted in the presenting behaviour (together with the patient's insight), rather than the clinical symptomology and aetiology of the condition. Despite this contrast, it is also clear that Parliament intended "*mental disturbance*" to generally be found in the disciplines of psychiatry and psychology.[20]

The Evidence, Facts Found and Determination

24. The Certificate and Report were tendered at the hearing and became Exhibit P1. In addition, various email correspondence was also tendered.[21] That was with a strong caveat as to any weight which might be accorded to their content in the circumstances. The primary evidence comprised the Certificate and Report, supplemented by oral evidence of the Report's author, DMHP Ms Jarczyk.

25. The Prosecution's submission in relation to the prominence which s 6(2) ought be given in construing and applying s 77 is well made and noted. Associated with that is the caution counselled by DSM-5 is also important, namely;

> *Although the DSM-5 diagnostic criteria and text are primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning, DSM-5 is also used as a reference for the courts and attorneys in assessing the legal consequences of mental disorders.* ***As a result, it is important to note that the definition of mental disorder included in DSM-5 was***

[18] That is in contrast to ss 9, 10 and 13, *Principles relating to the provision of treatment and care* and *Principles relating to involuntary admission and treatment* and *Principles relating to rights and conditions in approved treatment facilities*, which expressly addresses each condition.

[19] Sections 14, 15 and 15A of the MH&RS Act. Perhaps unsurprisingly, given the breadth of situations and conditions which may be generically described as 'mental health issues', voluntary admission entails no such trichotomy. The predominant criterion for voluntary admission provided by s 25 is simply that a "*medical practitioner or authorised psychiatric practitioner is satisfied that the person is likely to benefit from being admitted*".

[20] See ss 30, 31, 34, 37, 38 and 44 for example.

[21] Exhibits D2 and D3.

developed to meet the needs of clinicians, public health professionals, and research investigators rather than the technical needs of the courts and legal professionals. *It is also important to note that DSM-5 does not provide treatment guidelines for any given disorder. When used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination.* ***By providing a compendium based on a review of the pertinent clinical and research literature, DSM-5 may facilitate legal decision-makers' understanding of the relevant characteristics of mental disorders.*** *The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual.* ***Finally, diagnostic information about longitudinal course may improve decision-making when the legal issue concerns an individual's mental functioning at a past or future point in time. However, the use of DSM-5 in forensic settings should be informed by an awareness of the risks and limitations of its use. When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-5 mental disorder such as intellectual developmental disorder (intellectual disability), schizophrenia, major neurocognitive disorder, gambling disorder, or pedophilic disorder does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or "mental illness" as defined in law, or a specified legal standard (e.g., for competence, criminal responsibility, or disability). For the latter, additional information is usually required beyond that contained in the DSM-5 diagnosis, which might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of risk, impairment, or disability. Use of DSM-5 to assess the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised. Nonclinical decision-makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the etiology or causes of the individual's mental disorder or the individual's degree of control over behaviors that may be associated with the disorder. Even when diminished control over the individual's own behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time*** (**emphasis** added).

26. The evidence of DMHP Jarczyk was careful, considered and satisfied the requirements of *Makita (Aust) Pty Ltd v Sprowles*.[22] That included having primary regard to manifest symptomology, and absence of history of mental illness, and the presence of various psychosocial stressors which may explain Ms RNB's aberrant behaviour over the four-day period. Most relevantly, Ms Jarczyk concluded that the possibility of mental illness was contraindicated by the likelihood of a postictal state and, perhaps, adverse side-effects of a change in medication. Each of those possibilities were associated with Ms RNB's

[22] (2001) 52 NSWLR 705 - The factual foundations on which the DMHP's opinions were based, summarised under *Sources of Information* in the report of 3 April 2024 which became exhibit P1 were articulated and comprehensive.

well- recognised chronic epilepsy. Ms Jarczyk's opinion that Ms RNB was not suffering mental illness at the relevant time is well-established and accepted.

27. DMHP Jarczyk noted that when first reviewed on 1 August 2023 following coming into custody, the Forensic Mental Health Team concluded that her symptomology was not one of psychosis, but perhaps "*delirium and possible medication induced behavioural disturbance*". Medical records documented "*disorientation, thought disorder, occasional visual and auditory hallucinations, fluctuating agitated delirium, attempted self-harm and aggression*". Ms Jarczyk's opinion was that Ms RNB was probably suffering "*a temporary brain condition following seizures manifesting neurological deficits and/or psychiatric symptoms*" and that "*the diagnosis of postictal* [state] *was clear*". That state included auditory hallucinations from God and the Devil, and a voice telling her "*here she comes*" on one occasion. On another, Ms RNB reported someone had told her to disrobe in the presence of contractors working at Galiwinku.

28. The oral evidence provided at hearing included that Ms RNB's condition did not satisfy s 77(1)(a) of the MH&RS Act because its aetiology was organic, in that the symptomology of her presentation was physiological in nature, so did not qualify.[23] Also, that the presentation was perhaps best described as "*delirium*". It is noted that alternative conditions of "*mental illness*" and "*mental disturbance*" provided for by s 77 are dealt with in a composite fashion in the Certificate. Lastly, except for the reference in the penultimate paragraph of page 15 of the Report, "*mental disturbance*" does not specifically feature as a consideration.[24]

29. Given the respective definitions contained in the MH&RS Act, the symptomology documented in the medical records together with Ms RNB's behaviour raises a real possibility of "*mental disturbance*". That gives rise to a question of whether Ms RNB's state 'justified' involuntary admission.[25] The expert opinion is clear that any such admission could not have been on the basis of "*mental illness*", due to that condition not afflicting Ms RNB. However, Ms RNB can be said to have been experiencing a very definite deviation from her "*customary or everyday ability to reason and function in a socially acceptable and culturally appropriate manner*" and was "*behaving in an abnormally aggressive manner or is engaging in seriously irresponsible conduct that* [would] *justify a determination that the person requires psychiatric assessment, treatment and care*".

30. As matters stood, Ms RNB was arrested on 27 July 2023 and subsequently subjected to various medical assessment, treatment and care while in custody.[26] In my view the criteria prescribed by s 15(c), (d) and (e) of the MH&RS Act were satisfied to the necessary standard. That conclusion is all the more open due to the direction of s 6(2) only expressly relating to "*mental illness*", and despite my view that the "*accepted clinical standards*" referred to must also apply to the conditions of "*mental disturbance*" and "*complex cognitive impairment*". That the focus of

[23] That organic genesis may have been postictal through earlier seizures or due to a change in medication, or a combination of both. See DMHP Jarczyk's oral evidence on 12 February 2025.

[24] The alternative states of "*mental illness*" or "*mental disturbance*" are sought to be addressed compendiously as "*mental illness or disturbance*".

[25] See the definition of "*mentally disturbed*". It was common ground that Ms RNB had not at any time during the episode been admitted involuntarily to any approved treatment facility under the MH&RS Act. However, the relevant definition is that the "*mental disturbance*" must be such as to "*justify*" involuntary admission.

[26] Section 15(b)(i) and (ii) of the MH&RS Act.

those standards is predominantly "*mental illness*" entails an increased degree of clinical imprecision in relation to the remaining two states.

31. Each of the incidents giving rise to the Charges occurred in the remote community of Galiwinku, where immediate and benchmark clinical expertise and assessment were not likely available. It is also the case that, following arrest and incarceration, RNB was admitted to Royal Darwin Hospital, albeit not as an involuntary patient on either of the Mental Health Wards, despite being an 'At Risk' admission. That was in circumstances which required no informed consent. It may also be accepted that, although "*mental disturbance*" can result in involuntary admission to such a specialist Ward, the condition is not a "*mental illness*", which is the primary focus of Authorised Psychiatric and Designated Mental Health Practitioners practising on those Wards. Similarly, the legislated and clinical foci of the MH&RS Act and clinicians authorised or designated under the scheme is also mental illness. That perspective is not distracted or diluted by any clear definition being provided for the condition of "*mental disturbance*".

32. Nonetheless, prior to, during and following the relevant four day period Ms RNB was observed to present with the range of symptoms and behaviours documented in the medical notes referred to in the *Sources of Information* section of the Report, referred to at [27] to [29] above, including delirium.

33. In the circumstances of the presentation of Ms RNB in and around the four days of offending behaviour, together with the expert evidence provided to the court in the proceedings, I consider Ms RNB has proven of the balance of probability that she was suffering from "*mental disturbance*" at the relevant times. Secondly, that as a result, she was not able to control her actions.

34. Those conclusions may also raise issues not simply of moral culpability, but the intent required by Part II or IIAA of the *Criminal Code*. The extent of that difficulty would likely prevent the application of s 10 of the *Sentencing Act 1995*. However, if my conclusion under s 77 of the MH&RS Act were wrong, I would alternatively proceed to dismiss the Charges under s 69 of the *Local Court (Criminal Procedure) Act 1928*.

Dated this 28th day of July 2025