Do New Zealand Psychiatrists Have a Duty to Protect Potential Victims of their Patients' Violence?

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Chapter 1: Introduction

This paper examines the imposition on psychiatrists in New Zealand of a novel duty to take reasonable care to protect potential victims from the violence of their patients. A recent report[1] found that, in the 2012/2013 year, District Health Boards (DHBs) around New Zealand reported 177 "serious adverse events" in mental health and addiction services.[2] 17 were reported as "serious adverse behaviour", which included assaults by patients and allegations of criminal acts.[3] There have been several high profile cases where psychiatric patients acted violently while under the care of mental health services, or having recently left such care. For example, in 2001, Mark Burton murdered his mother the day after his release from Southland Hospital's inpatient unit, where he was being treated for paranoid schizophrenia.[4] This dissertation examines whether psychiatrists could be liable in the tort of negligence where their patient injures another person, on the basis that the psychiatrist failed to protect that person. Negligence liability of this kind has not yet been imposed in New Zealand, and would require an extension of the law. This dissertation therefore considers one aspect of the tort of negligence: the imposition of a novel duty of care.[5] It aims to decide, first, whether a duty would be imposed in any circumstances, and if so, to outline what those circumstances might be.

Recognition of such a duty occurred in the Californian case of *Tarasoff v The Regents of the University of California*.[6] Prosenjit Poddar, a student at the University, confided in a campus psychologist that he intended to kill another student, Tatiana Tarasoff.[7] The psychologist asked campus police to take Poddar into custody. They did so, but

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[1] Health Quality and Safety Commission New Zealand *District Health Board mental health and addictions services: Serious adverse events reported to the Health Quality & Safety Commission 1 July 2012 to 30 June 2013* (Health Quality and Safety Commission, Wellington, 2013).
[2] At 2.
[3] At 2.
[4] "Mark Burton frightened mother a year before murder" *The New Zealand Herald* (online ed, Auckland, 27 November 2001).
[5] The other requirements for negligence liability, namely breach of the duty, causation, and damage, will not be considered.
[6] *Tarasoff v The Regents of the University of California* 551 P 2d 334 (Cal 1976).
[7] At 432. While Tarasoff was not identified by name to the psychologist, she was nevertheless "readily identifiable".

released him when he appeared rational. Two months later, he killed Tarasoff. The majority judgment said:[8]

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty […] may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

The general rule in New Zealand tort law is that a person has no obligation to protect someone else from the dangerous behaviour of a third party.[9] However, in *Couch v Attorney-General*,[10] the New Zealand Supreme Court suggested that negligence liability may be imposed upon the Department of Corrections for failure to protect Susan Couch from injuries caused by a prisoner on parole. This is an analogous situation to that considered here.

In deciding whether to impose a novel duty of care, New Zealand courts have said there are two main inquiries. The first is proximity between defendant and plaintiff, and the second is policy, examining whether it would be "fair, just and reasonable" to impose a duty on the defendant. This paper will be organized around those two inquiries. It will first consider the current, equivocal position of New Zealand law on the liability of psychiatrists for the behaviour of their patients. It will then discuss the general principles relevant to imposing a novel duty of care in New Zealand. The next two chapters will then address in depth the inquiry into proximity between the psychiatrist and the potential victim, and the relevant policy factors. The policy chapter will be divided into two parts, the first considering the policy embedded in the relevant statutory framework, the second considering other policy arguments. The

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[8] At 431.

[9] *Couch v Attorney-General* [2008] NZSC 45 at [100]; *Van de Wetering v Capital Coast Health Ltd* HC Wellington CP368/98, 19/05/2000 at 10; *Maulolo v Hutt Valley Health Corporation Ltd* HC Wellington CP212/99, 20/07/2001 at [9]. In this dissertation, "third party" will refer to the third party to litigation between a defendant psychiatrist and an injured plaintiff, not to a third party to the therapeutic relationship. That is, the third party is the violent patient – not the potential victim.

[10] *Couch v Attorney-General* [2008] NZSC 45.

final chapter will conclude whether such a duty is likely to be recognised in New Zealand, and in what circumstances.

In this dissertation, the terminology of "duty to protect" will be used, in line with the *Tarasoff* decision. The two main methods of discharging such a duty, for a psychiatrist, will be through warning the potential victim or detaining the patient compulsorily.[11]

This dissertation focuses on the negligence liability of psychiatrists. However, psychiatrists in New Zealand are generally employed by DHBs, which are likely to be vicariously liable for the actions of their employees. DHBs are public bodies, and therefore general principles relating to the negligence liability of public bodies will apply.

Finally, the statutory bar on compensatory damages for personal injury in New Zealand means that most claims for damages for breach of this duty will have to be for exemplary damages,[12] usually awarded only in cases of gross negligence.[13] Alternative remedies will also be available, such as declarations that a breach of the duty of care occurred. However, my concern is to determine when, in principle, a psychiatrist should be considered to be under a legal duty to protect potential victims.

[11] Some proximity and policy arguments will only be relevant to one of those two methods, and where this is so it will be noted.
[12] Accident Compensation Act 2001, s 317 and 319. The statutory bar will not apply where the claim is for a pure mental injury or for other forms of harm such as property damage.
[13] See *Bottrill v A* [2003] 2 NZLR 721 (PC) at [37] per Lord Nicholl: exemplary damages require "truly exceptional and outrageous" conduct, as cited in *Couch*, above n 10, at [11].

Chapter 2: The Current Position in New Zealand Law

A. New Zealand Cases on the Liability of Psychiatrists

Cases have been brought in New Zealand against psychiatrists alleging negligence, where people who are mentally ill have harmed others. In these cases, the plaintiffs have generally not succeeded.[14] However, the courts have suggested the elements of liability that would need to be established.[15] This chapter will outline those cases, and they will be revisited in the proximity chapter for an in-depth discussion of their proximity implications.

1. Van de Wetering v Capital Coast Health Limited[16]

Van de Wetering involved a voluntary mental health patient who had shot dead his father and two others.[17] He was found not guilty of murder by reason of insanity. The plaintiffs argued that the DHB owed them a duty of care as members of the public to take active steps to prevent the patient from harming them.[18]

Master Thomson focused on the two broad fields of proximity and policy.[19] He found that there was insufficient proximity between the defendant and members of the public at large.[20]

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[14] It should be noted that this dissertation only considers the situation where a psychiatrist does not already have a pre-existing relationship with the potential victim. If there is a pre-existing relationship, such as where the victim is also their patient, the psychiatrist is more likely to owe them a duty of care.

[15] All of the cases concerned strike out applications, so where the plaintiff succeeded, all that can be said is that a duty of care was arguable.

[16] *Van de Wetering v Capital Coast Health Limited* HC Wellington CP368/98, 19/05/2000.

[17] At 4.

[18] At 2. The fact that the case was pleaded in this way is unusual. The deceased were the father of the patient, a family friend and a neighbour, and the plaintiffs were the family members of the deceased. Therefore the plaintiffs were arguably not just "members of the public". However, the Master determined the case on the basis of the pleaded duty being owed to all members of the public.

[19] At 5.

[20] At 9.

He also thought that policy factors pointed against a duty. Imposing a duty on psychiatrists could cause them to practise defensively,[21] through being overcautious in issuing certificates under the legislation.[22] This may cut across the duty to act in the patient's best interests.[23] Such a duty would also be inconsistent with New Zealand's Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CA&T)A), which aims to treat patients in the least restrictive environment.[24] Finally, Master Thomson said that liability would be indeterminate in scope.[25] Thus, in *Van de Wetering* a duty of care was not supported by either proximity or policy.

2. Maulolo v Hutt Valley Health Corporation Limited[26]

Maulolo involved the murder of Fiona Maulolo by Leslie Parr, of which Parr was found not guilty by reason of insanity.[27] Parr had been a compulsory patient of Hutt Valley Health, but had been discharged a year prior to the murder.[28] The plaintiffs argued that they were owed a duty to avoid psychiatric injury to them, as members of the deceased's "immediate family circle".[29] However, Master Thomson concluded that the plaintiffs could not distinguish themselves from the plaintiffs in *Van de Wetering*, and thus their proximity argument failed.[30]

In terms of policy arguments, the same factors that applied in *Van de Wetering* also applied in *Maulolo*, namely defensive practice, inconsistency with duties under the MH(CA&T)A, and indeterminate scope.

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[21] At 16.
[22] At 17.
[23] At 17.
[24] At 16. If a psychiatrist faces liability, they may decide to protect themselves by detaining potentially violent patients, when they would otherwise have treated them less restrictively. See the section on the MH(CA&T)A in the policy chapter for in-depth discussion of this inconsistency.
[25] At 18.
[26] *Maulolo v Hutt Valley Health Corporation Limited* HC Wellington CP212/99, 20/07/2001.
[27] At [6].
[28] At [5].
[29] At [7].
[30] At [16].

In a review of Master Thomson's decision,[31] Wild J agreed that there was insufficient proximity. He also concurred with Master Thomson that the policy factors negated the existence of a duty of care.[32] Therefore, the plaintiffs' claim again failed in both the proximity and policy inquiries.

3. S v Midcentral District Health Board (No 2)[33]

In *Midcentral*, the plaintiff was a female patient who had been raped by another patient, P. P had been an inpatient, but at the time of the rape he was on a leave of absence.[34] The rape victim had attended the same outpatient service as him.[35] William Young J decided that there was sufficient proximity,[36] as the plaintiff, being a patient herself, could be distinguished from the general public.

In the policy inquiry, it was said that imposing negligence liability on psychiatrists may frustrate the goals of the MH(CA&T)A.[37] Doctors generally might begin to practise defensively in response to liability.[38] However, William Young J differed from *Van de Wetering* and *Maulolo*, finding that these policy considerations were not decisively against a duty.[39] Thus the plaintiff made out an arguable case for a duty of care to be imposed.

4. Ellis v Counties Manukau District Health Board[40]

In *Ellis*, the plaintiff was the patient himself. He sued the DHB for failing to detain him while being assessed under the MH(CA&T)A. Ellis had killed his father two weeks after being released, and was found not guilty by reason of insanity.[41] Potter J

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[31] *Maulolo v Hutt Valley Health Corporation Limited* HC Wellington CP212/99, 29/11/2001.
[32] At [37].
[33] *S v Midcentral District Health Board (No 2)* [2004] NZAR 342.
[34] At [15]. This leave of absence had been strongly opposed by P himself.
[35] At [17].
[36] At [48].
[37] At [27]. The goals would be frustrated by putting too much emphasis on public safety and diminishing patients' rights.
[38] At [47].
[39] At [48].
[40] *Ellis v Counties Manukau District Health Board* [2007] 1 NZLR 196 (HC).
[41] At [16].

found there was insufficient proximity between the defendant and Ellis,[42] as Ellis had not been under the control of the DHB at the time of the murder.

Three policy factors were considered to support the imposition of a duty of care. These were that the "first claim on the loyalty of the law is that errors should be remedied", that clinicians are expected to carry out their duties under the MH(CA&T)A with reasonable care and skill anyway, and that the mentally unwell are especially vulnerable and reliant on clinicians exercising reasonable care and skill.[43] However, there were stronger policy arguments against the imposition of a duty,[44] including avoiding defensive practice of health professionals, inconsistency with the primary duty to the health of the patient, and alternative remedies being available to the plaintiff.[45] Therefore the plaintiff's claim failed in both the proximity and policy inquiries.

B. Couch v Attorney-General

Couch concerns an analogous situation to that of psychiatrist and patient (albeit not involving a therapeutic relationship), and is therefore important when considering extending the law on duties of care. Susan Couch was suing the Department of Corrections for their allegedly negligent supervision of a parolee, William Bell. Bell had been permitted to work at an RSA bar, despite his known alcohol addiction and prior record of violent robberies to support it. One morning he robbed the RSA, and in the course of doing so, murdered three employees and grievously injured Couch.

Blanchard, Tipping and McGrath JJ in the majority formulated a principle for sufficient proximity: if the potential victim is an individual or a member of an "identifiable and sufficiently delineated class", and is or should be known by the defendants to be the "subject of a distinct and special risk of suffering harm of [that]

[42] At [167].
[43] At [170].
[44] At [171].
[45] At [171]. These remedies included making a complaint to the Health and Disability Commissioner.

kind", there will be sufficient proximity.[46] They decided that Couch had an arguable case under this principle.[47]

Couch did not address policy issues, the court preferring to leave them for trial. However, the case was settled out of court,[48] and thus the finding that proximity was arguable is the only guidance provided.

C. Summary

Van de Wetering and *Maulolo* involved plaintiffs who were said to be not proximate because a duty could not be owed to the general public. *Ellis* involved a plaintiff who was not proximate due to a lack of control over the perpetrator by the DHB. In all three cases, policy arguments militated against imposing a duty. *Midcentral* and *Couch* were cases where a duty of care was found to be arguable, but both differ materially from the situation considered in this dissertation. *Midcentral* involved a plaintiff who had a pre-existing relationship with the defendant, and *Couch* did not involve issues relevant to the psychiatric context.

This is as far as the New Zealand cases currently go. The law will therefore need to be extended in order to cover psychiatrists owing a duty to protect potential victims with whom they do not have a pre-existing relationship from their patients' violence. The general legal principles governing novel duties of care, including proximity and policy, will now be considered in this light.

[46] At [112].
[47] At [124].
[48] See "Corrections Department pays RSA survivor $300,000" *The New Zealand Herald* (online ed, Auckland, 6 December 2012).

Chapter 3: General Principles for the Recognition of a Novel Duty of Care

This chapter aims to provide an understanding of the broad principles surrounding the imposition of a novel duty of care. These principles will be discussed in the specific context of psychiatrists owing a duty to protect potential victims in the following chapters.

A. History of the Proximity and Policy Inquiries

In *Anns v Merton London Borough Council*,[49] the House of Lords devised the two-stage approach, saying that if there was sufficient proximity, a prima facie duty of care would arise.[50] The court would then look to factors that would negate the duty (i.e., the policy inquiry).[51] This approach allowed courts to take a comparatively liberal view of when a duty of care was owed.

Twelve years later, in *Caparo Industries v Dickman*,[52] the House of Lords backtracked from *Anns*. Lord Bridge and Lord Oliver referred with approval to a decision of Brennan J,[53] where he said, "the law should develop novel categories of negligence incrementally and by analogy with established categories".[54] The House of Lords adopted a three-stage approach, consisting of foreseeability of damage to the plaintiff, a relationship of proximity between plaintiff and defendant, and a situation in which imposition of a duty of care is "fair, just and reasonable".[55] Then, in *Murphy v Brentwood District Council*,[56] the House of Lords confirmed that *Anns* had been wrongly decided.[57]

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[49] *Anns v Merton London Borough Council* [1978] AC 728.
[50] At 751H per Lord Wilberforce.
[51] At 752A per Lord Wilberforce.
[52] *Caparo Industries plc v Dickman* [1990] 2 AC 605.
[53] *Sutherland Shire Council v Heyman* (1985) 60 ALR (HCA), as cited at 618D per Lord Bridge and at 633G per Lord Oliver.
[54] *Sutherland Shire Council v Heyman*, above n 78, at 43-44, as cited in *Caparo*, above n 52, at 618D per Lord Bridge and 633G per Lord Oliver.
[55] *Caparo,* above n 52, at 618A-B.
[56] *Murphy v Brentwood District Council* [1991] 1 AC 398.
[57] See, for example, 457 per Lord Mackay and 472 per Lord Keith.

Following *Caparo*, New Zealand continued to follow the two-stage approach in *Anns*.[58] The legal community "had to hold its collective legal breath"[59] for four years before the Privy Council decided in *Invercargill City Council v Hamlin*[60] to leave the New Zealand approach alone, meaning *Caparo* did not explicitly become part of New Zealand law.

However, in *South Pacific Manufacturing*,[61] the New Zealand Court of Appeal followed *Anns* but also considered whether a duty would be "just and reasonable", an approach similar to that in *Caparo*.[62] In 2012 the Supreme Court in *The Grange*[63] noted the importance of previously recognised categories of duties in imposing novel duties of care,[64] thus moving closer to the "incremental" *Caparo* approach.[65] Nevertheless, in *Couch*, Elias CJ and Anderson J stated that despite the overturning of *Anns* in England, "in New Zealand we have tended to take the view that no substantial difference in result follows the changes in emphasis."[66]

Therefore, in New Zealand the imposition of a novel duty of care depends initially upon there being sufficient proximity between the parties, and this requires more than just foreseeability. It must also be "fair, just and reasonable" for a duty to be imposed on the defendant, otherwise known as the policy inquiry.

In *Rolls-Royce New Zealand v Carter Holt Harvey*,[67] Glazebrook J said there was no clear-cut boundary between the proximity and policy inquiries, as each stage may involve consideration of the same factors.[68] In the English case of *Stovin v Wise*,[69] it was said "[p]roximity is convenient shorthand for a relationship between two parties

[58] Andrew Barker "One test to rule them all (and of inferior courts to bind them)" (2012) 190 NZLawyer 14.
[59] Barker, above n 58, at 14.
[60] *Invercargill City Council v Hamlin* [1996] 1 NZLR 513.
[61] *South Pacific Manufacturing Co Ltd v NZ Security Consultants & Investigations Ltd; Mortensen v Laing* [1992] 2 NZLR 282.
[62] At 297 per Cooke P and at 305 per Richardson J.
[63] *North Shore City Council v The Attorney General as successor to the assets and liabilities of the Building Industry Authority* [2012] NZSC 49.
[64] See [182].
[65] Barker, above n 58, at 15.
[66] *Couch*, above n 10, at [52].
[67] *Rolls-Royce New Zealand Ltd v Carter Holt Harvey Ltd* [2005] 1 NZLR 324.
[68] At [64].
[69] *Stovin v Wise* [1996] AC 923.

which makes it fair and reasonable one should owe the other a duty of care."[70] This recognises that policy factors will inevitably be considered for both the proximity and policy inquiries.

B. The Proximity Inquiry

1. Vulnerability and general reliance

Specific reliance means the plaintiff in fact counted upon the defendant to do something, whereas general reliance is implied. It will be the exception for a potential victim to ask a psychiatrist to warn them if a patient poses a danger, so it will be necessary to demonstrate that general reliance is enough for proximity.

Gartside v Sheffield, Young & Ellis[71] involved the alleged negligence of a solicitor in failing to make requested changes to the will of an elderly lady before her death. There was no specific reliance by the intended beneficiary, due to not knowing they were to inherit.[72] Nevertheless, the court found the solicitor liable for negligence, as otherwise the plaintiff would have no remedy.[73]

In *Brownie Wills v Shrimpton*,[74] the Court of Appeal reversed a decision to impose a duty of care on a lawyer to ensure that a company director fully understood the guarantee he was giving. The plaintiff was an experienced businessman, and could have obtained independent advice or asked the solicitor concerned to act for him.[75] The Court distinguished *Gartside* because a beneficiary under a will is totally dependent on the testator's solicitor, whilst a company director giving a guarantee is not in such a vulnerable position.[76]

[70] At 932.
[71] *Gartside v Sheffield, Young & Ellis* [1983] NZLR 37 (CA).
[72] At 42 per Cooke J and at 46 and 50 per Richardson J.
[73] At 43 per Cooke J and at 51 per Richardson J.
[74] *Brownie Wills v Shrimpton* [1998] 2 NZLR 320.
[75] At 323.
[76] At 325-326.

In *Price Waterhouse v Kwan*,[77] clients of a solicitors' firm had invested in the firm's nominee company. The money was lost, and the clients sued the auditors of the company for negligence. The Court of Appeal said that the main purpose of the statutory requirement for auditing solicitors' nominee companies was to protect clients from loss as a result of misbehaving solicitors.[78] Therefore, clients were entitled to "rely generally" on the audit scheme, and this was enough for proximity.[79]

In *Rolls-Royce*, Carter Holt Harvey (CHH) entered into a contract with ECNZ, who in turn entered into a contract with Rolls-Royce to build a co-generation plant. Glazebrook J said the strongest factor supporting proximity was that it was clearly foreseeable that negligent performance by Rolls-Royce would cause loss to CHH.[80] However, CHH was not a vulnerable party – it could have contracted with Rolls-Royce directly in order to protect itself, but had decided not to for commercial reasons.[81] Therefore, there was insufficient proximity between the parties.

These cases all indicate that general reliance will be enough for proximity when the plaintiff is in some way vulnerable. Plaintiffs who should have known better will likely have to prove specific reliance. Therefore, it will need to be determined whether a potential victim who is at risk from a violent patient is a vulnerable plaintiff.

2. A sufficiently delineated class

The majority decision in *Couch* means that a potential victim will also need to show that they were part of an identifiable and sufficiently delineated class at a distinct and special risk.[82] This formulation aimed to address concerns about expansive liability

[77] *Price Waterhouse v Kwan* [2000] 3 NZLR 39.
[78] At [16].
[79] At [16]. Compare *Boyd Knight v Purdue* [1999] 2 NZLR 278 at [54], where the plaintiff was unable to rely generally on auditors. Specific reliance was needed in that case, arguably because the plaintiff had invested in a high-risk, high return company, unlike the investors who were statutorily protected in *Price Waterhouse v Kwan*.
[80] *Rolls-Royce*, above n 67, at [101].
[81] *Rolls-Royce*, above n 67, at [104].
[82] *Couch*, above n 10, at [112].

for the actions of others. The requirement of a "sufficiently delineated" class will be discussed below in the proximity chapter.

As for a distinct and special risk, the simple fact of frequent physical proximity will not be enough.[83] The characteristics of the wrongdoer, as well as the circumstances in which the wrongdoer comes into contact with the potential victims, will be relevant.[84] Thus, the class of "employees present at the RSA premises" was considered a sufficiently delineated class due to Bell's personal characteristics and modus operandi of inflicting gratuitous violence during robberies.[85]

The minority in *Couch*, Elias CJ and Anderson J, disliked the majority's "rigid relational requirement",[86] and thought that the proximity inquiry should be wider, without too much emphasis placed on the plaintiff being a member of a sufficiently delineated class.[87]

3. A "special relationship"

In *Couch*, the majority judgment discussed the existence of a "special relationship" between the defendant and the immediate wrongdoer.[88] A relationship will be special if the defendant had "sufficient power and ability to exercise the necessary control over the immediate wrongdoer".[89] Thus, a psychiatrist will need to have the ability to exercise control over the violent patient in order for a duty to be owed.

C. The Policy Inquiry

1. The statutory background

As mentioned above, psychiatrists in New Zealand are largely employed by DHBs. Therefore, general principles regarding the negligence liability of public bodies will

[83] *Couch*, above n 10, at [120].
[84] *Couch*, above n 10, at [120].
[85] At [124].
[86] At [48].
[87] At [67].
[88] At [81]-[84].
[89] At [82].

be relevant to whether a duty to protect should be imposed. This section lays out those principles, and they will be applied to the relevant statutory framework in the policy chapter.

(a) Conflict between a statute and a common law duty of care

In *Phelps v Hillingdon London Borough Council*,[90] Lord Slynn said that just because a statutory regime already addressed a situation, it did not mean that a common law duty that "would otherwise exist" should be denied.[91] However, if a common law duty would conflict with a statutory duty, it cannot be imposed.[92] If there are no specific statutory duties imposed, a common law duty of care cannot cut across or undermine the purpose of the statute,[93] or lead to its aims being incorrectly prioritised.[94] This is a straightforward application of parliamentary sovereignty, whereby statutes take precedence over the common law.

Thus in *B v Attorney-General*, the Privy Council stated that while a duty of care was owed to the children in a sexual abuse allegation, no duty was owed to the father.[95] This was because "the interests of the alleged perpetrator and of the children as the alleged victims are poles apart",[96] so if the department owed a duty of care to parents, their primary duty to children would be compromised. Similarly, in *Prince and Gardner*,[97] it was held that recognising a duty on social workers to take care when reporting on prospective adoptive parents would cut across the statutory regime.[98]

[90] *Phelps v Hillingdon London Borough Council* [2001] 2 AC 619.
[91] At 649.
[92] At 650.
[93] Cherie Booth and Dan Squires *The Negligence Liability of Public Authorities* (Oxford University Press, Oxford, 2006) at 225; Geoff McLay and Dean Knight "Government negligence" (paper presented to Liability of Public Authorities Seminar, New Zealand Law Society, Wellington, June 2009) 13 at 23.
[94] Booth and Squires, above n 93, at 188.
[95] *B v Attorney-General* [2003] UKPC 61 at [30]. In this case, two girls were removed from their father's custody after one made allegations of sexual abuse against him. It eventually emerged that the allegations were probably false.
[96] At [30].
[97] *Attorney-General v Prince and Gardner* [1998] 1 NZLR 262 (CA).
[98] At 276.

This was because adoption was intended to be final, and such a duty would mean that the adoption could be re-examined later for the purposes of civil liability.[99]

Booth and Squires summarise this principle by saying that where a statute is enacted to protect a particular group, then "a duty of care will not be imposed if it would discourage public authorities from providing the intended protection."[100] So, in the mental health context, if the statute is designed mainly to protect the mentally ill or promote their health, then its powers should not be used in a way that subverts those aims.

(b) Statutory support for a common law duty of care

On the other hand, the absence of conflict between the statutory background and a common law duty of care does not necessarily mean the duty is supported. The majority in *Couch* stated that the relevant statute was neutral on the point of a common law duty of care, and "[t]he most that can be said is that the duty [of probation officers under the statute] would not conflict with a common law duty."[101]

Nevertheless, the statutory background can provide support for a common law duty in some situations. In *Couch*, Elias CJ made the sweeping statement that "[s]ince [the probation service] was obliged to exercise its statutory powers reasonably, a duty of care in negligence would "march hand in hand" with statutory responsibilities.[102] In *Stovin*, Lord Nicholls in the minority said that if a common law duty would not require a public authority to act any differently, then a "major impediment" to the imposition of a duty was absent.[103] The principle stated by Booth and Squires above can also be reversed, so that if imposition of a duty would encourage public authorities to provide intended protection to a particular category of persons, then its imposition may be supported. Therefore, if the MH(CA&T)A is also designed to

[99] At 276. See also generally on the conflict between statutes and common law duties: *Jain and another v Trent Strategic Health Authority* [2009] UKHL 4 and *Attorney-General v Carter* [2003] 2 NZLR 160.
[100] Booth and Squires, above n 93, at 209.
[101] At [111].
[102] At [58].
[103] *Stovin v Wise*, above n 69, at 935.

promote public safety, then this may support a parallel duty of care towards potential victims under the common law.

(c) Relationship between a statutory discretion and a common law duty of care

Some statutes do not impose duties but give public authorities powers or discretions. Negligence may then be alleged due to the failure to exercise a discretionary power. Imposing a common law duty of care in this situation would amount to turning a statutory "may" into a common law "ought".[104] This is generally seen as a difficult step to take.[105] In *Amaca v New South Wales*,[106] Ipp JA noted the general principle that where a public authority is not statutorily required to exercise a power, it will not owe a common law duty to exercise that power.[107] The simple fact that an authority has statutory powers that, if exercised, may prevent harm to others, does not alone impose a duty of care upon it.[108] This was confirmed in *Stovin*, where Lord Nicholls said that reliance on a public authority will usually not be enough for a common law duty to arise – otherwise duties would be imposed in "almost every case".[109] Nevertheless, Lord Hoffman in *Stovin* stated that Parliament might not have wanted to impose a statutory duty but still have envisaged that a public authority could be sued where a power had been irrationally exercised or not exercised at all.[110] However, he went on to say that the fact that only a discretion was conferred is an indication that Parliament did not intend to create a right to compensation, and exceptions will be rare.[111]

[104] See *Stovin v Wise*, above n 69, at 948.
[105] *Stovin v Wise*, above n 69, at 948.
[106] *Amaca Pty Ltd (formerly James Hardie & Co Pty Ltd) v New South Wales* [2004] NSWCA 124.
[107] At [21].
[108] *Amaca*, above n 106, at [64].
[109] *Stovin v Wise*, above n 69, at 938.
[110] *Stovin v Wise*, above n 69, at 953.
[111] *Stovin v Wise*, above n 69, at 953.

Lord Reid, in *Dorset Yacht Co Ltd v Home Office*,[112] noted that where a public authority has a discretion as opposed to a duty:[113]

> there [will] be errors of judgment in exercising such a discretion and Parliament cannot have intended that members of the public should be entitled to sue in respect of such errors.

However, he did say that where the discretion has been exercised so unreasonably that it has not really been exercised at all, it must be taken that Parliament did not intend for the authority to have immunity.[114] The use of a discretion instead of a statutory duty therefore does not conclusively signify that Parliament is against the imposition of a duty, and the statutes relevant to the mental health context that contain discretions rather than duties may still support the imposition of a common law duty.

(d) Influence of statutory remedies on a common law duty of care

Another important factor is the provision of statutory remedies, as Parliament might have intended those remedies be the only ones available.[115] Booth and Squires state that statutory remedies can preclude common law claims.[116] However, Parliament might have simply intended to leave common law remedies for the courts to develop. Perhaps an explicit statutory bar is required to truly preclude common law claims for compensation, as in the Accident Compensation Act 2001.[117] In *Phelps* it was decided that a common law duty should not be imposed, due to the "general nature" of the statutory duties and the statutory remedies available by way of appeal and judicial review.[118] However, it may well be that a common law duty is necessary to "fill the gap" if public law remedies are inadequate.[119] In the case of physical injury resulting from the exercise or non-exercise of a public authority's powers, it is unlikely that judicial review will be seen as an adequate remedy, as it does not compensate the

[112] *Home Office v Dorset Yacht Company* [1970] AC 1004.
[113] At 1031.
[114] *Dorset Yacht Company*, above n 112, at 1031.
[115] Booth and Squires, above n 93, at 202.
[116] Booth and Squires, above n 93, at 207.
[117] See s 317.
[118] *Phelps*, above n 90, at 652.
[119] See *Stovin v Wise*, above n 69, at 940.

injury. So where the complainant has suffered a physical injury from a danger they were ignorant of, and the public authority knew of this danger, it is more likely that a duty of care will be imposed.[120]

South Pacific Manufacturing shows that if a relevant statute provides for disciplinary action for negligent behaviour, a duty of care could be supported.[121] Therefore, the fact that psychiatrists can be disciplined professionally for negligence does not necessarily count against a parallel duty of care, and may in fact support it.

(e) Summary on the statutory background principles

A common law duty cannot conflict with the statutory scheme. Some relevant statutes contain discretions, and so it will be important to consider if those statutory "mays" can be turned into common law "oughts". There are also some relevant alternative statutory remedies, and whether or not these remedies preclude the imposition of a common law duty of care will be discussed.

2. General policy considerations

Factors relevant to the general policy inquiry apply both to psychiatrists being sued directly, and to DHBs. They include the likely behaviour of other potential defendants in reaction to the decision (i.e., will it encourage defensive behaviour?);[122] the capacity of each party to insure against liability; the consistency of a duty of care with other areas of tort and contract law;[123] and the scope of liability.

In *Couch*, the minority discussed policy factors that supported the imposition of a duty, such as the public policy goals of vindication, insistence on proper standards and deterrence of negligent behaviour.[124] Positive policy factors such as providing a remedy for a wrong were also discussed in *Ellis*.[125]

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[120] *Stovin v Wise*, above n 69, at 939.
[121] *South Pacific Manufacturing*, above n 61, at 298 per Cooke P.
[122] See *Van de Wetering*, above n 16, at 16 and *Maulolo*, above n 26, at 7.
[123] *South Pacific Manufacturing*, above n 61, at 298 per Cooke P and at 314 per Casey J.
[124] At [69].
[125] *Ellis*, above n 40, at [170].

D. Summary

Essential aspects of the proximity inquiry can be summarised as follows. Where the plaintiff is vulnerable, general reliance will usually be enough for proximity. However, for the imposition of a duty of care to protect someone from the actions of a third party, there first needs to be a special relationship between the psychiatrist and the patient, as discussed in *Couch* and *Ellis*. The potential victim will also need to be an individual or part of a sufficiently delineated class facing a distinct and special risk of harm at the hands of the patient.

In terms of policy, the MH(CA&T)A and other important statutes will need to be scrutinised, along with other factors such as the risk of psychiatrists practising defensively in response to liability. Against this background of general principles, the proximity and policy inquiries in the mental health context will now be scrutinised.

Chapter 4: The Proximity Inquiry

Proximity is said to be the first consideration for imposing a novel duty of care. In this context, proximity is contentious because the presumption in tort law is that one does not have a duty to control a third party in order to prevent harm to someone else.[126] However, the concepts of foreseeability, vulnerability, special relationships and sufficiently delineated classes may be used to establish sufficient proximity between the psychiatrist and potential victim.

A. Foreseeability, Vulnerability and General Reliance

Where no reasonable person in the defendant's position would have foreseen damage,[127] there will not be proximity. Foreseeability is "at best a screening mechanism, to exclude claims which must obviously fail".[128] It is very likely that injury caused by a patient known to have violent propensities will be considered foreseeable. It would be unusual for a court to hold that no reasonable psychiatrist in that position would have foreseen the damage, as psychiatrists generally have a more intimate understanding of their patients than other people. Therefore foreseeability in this context will likely be satisfied. However, it must then be shown that the foreseeability was in the context of a proximate relationship.

General reliance upon the defendant will be enough to support a duty of care where the plaintiff is vulnerable. In the current context, potential victims will not usually have the knowledge to protect themselves, as they will not have the same insight into the patient's thoughts and mood as the psychiatrist.[129] Therefore they may be unable to avert the violence unless warned that it is a possibility.

Therefore, because potential victims will often be vulnerable vis-à-vis violent patients, their general reliance on the psychiatrist could provide support for a finding

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[126] *Couch*, above n 10, at [100]; *Van de Wetering*, above n 16, at 10; *Maulolo*, above n 26, at [9].
[127] *The Grange*, above n 63, at [157].
[128] *The Grange*, above n 63, at [157].
[129] See Shrikkanth Rangarajan and Bernadette McSherry "To Detain or Not to Detain: A Question of Public Duty?" (2009) 16(2) Psychiatry, Psychology and Law 288 at 294.

of proximity. However, because most potential victims do not have a direct relationship with the psychiatrist, they will also need to satisfy the requirements laid out in *Couch*, namely a special relationship between the psychiatrist and the patient, and the plaintiff being at a special and distinct risk as a member of a sufficiently delineated class.

B. Relationship Between Psychiatrist and Patient

The decision in *Couch* means that for sufficient proximity between a psychiatrist and a potential victim to arise, there needs to be a special relationship between the psychiatrist and the patient.[130] A relationship will be special where one party has a "peculiar ability" to affect the conduct of the other party.[131]

1. Actual custodial control

The key consideration for a special relationship is whether the psychiatrist has control over the patient. However, there is disagreement over the level of control required. Fleming and Maximov stated that the "usual cases" involving a special relationship were where the defendant had custodial control of another person.[132] However, they thought that whether a patient was an inpatient could not be decisive.[133] Instead, the mere existence of a doctor-patient relationship should be enough to impose a duty of care in respect to other parties.[134] Stone, in response to this, stated that when "control is eliminated, there is nothing in the […] relationship between a psychiatrist and his patient to support an exception to the tort law presumption."[135] He said that a therapist who was treating a patient as an outpatient had no control over that person.[136] Mendelson and Mendelson have also said that in Australia a duty of care should only

[130] See *Couch*, above n 10, at [81]-[84]. This "special relationship" between the psychiatrist and the patient is not to be confused with another use of the term "special relationship", where a psychiatrist has a pre-existing relationship with a victim.
[131] Robert Schopp and Michael Quattrocchi "*Tarasoff*, the doctrine of special relationships and the psychotherapist's duty to warn" (1984) 12 J Psychiatry & L 13 at 18.
[132] John Fleming and Bruce Maximov "The Patient or His Victim: The Therapist's Dilemma" (1974) 62(3) CLR 1025 at 1029.
[133] At 1029.
[134] At 1030.
[135] Alan Stone "The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society" (1976) 90 HVLR 358 at 366.
[136] At 366.

arise where the doctor has custodial control of the patient.[137]

Lord Keith in *Hill v West Yorkshire Police*[138] implied that actual control of the wrongdoer was vital for a duty to be owed to another. In *Hill*, a serial murderer named Peter Sutcliffe ("The Yorkshire Ripper") had murdered 13 women and attempted to murder seven others. The mother of one of his victims sued the West Yorkshire police, alleging negligence in failing to capture Sutcliffe before her daughter was murdered. Lord Keith compared the situation to the *Dorset Yacht* case, and found that a "vital characteristic" of that case was the fact that the Borstal boys had been in the custody of prison officers when they escaped.[139] In contrast, Sutcliffe had not been in custody when he committed his crimes, and thus there was no proximity between the plaintiff and police.[140]

2. The ability to assert control

Other cases indicate that actual custody is not necessary, and the ability to assert control will be enough. *Tarasoff* showed that even when a patient is an outpatient and the therapist did not have the "opportunity and responsibility" to assume their custody, a duty of care may still be imposed.[141]

In *Ellis*, Potter J stated that in considering proximity, the control of the defendant over the third party was an important consideration.[142] The DHB argued that it did not have

[137] Danuta Mendelson and George Mendelson "*Tarasoff* down under: the psychiatrist's duty to warn in Australia" (1991) 19 J Psychiatry & L 33 at 49. See also *Stuart v Kirkland-Veenstra* [2009] HCA 15 as cited in Russ Scott "The Duty of Care Owed by Police to a Person at Risk of Suicide" (2010) 17 Psychiatry, Psychology and Law 1 at 15, where the majority said that the defendant police had no control over the harm posed to the plaintiff's suicidal husband, as he himself was the danger. They found that no duty of care was owed. See also Rangarajan and McSherry, above n 129, at 290, where it was stated that the control of the psychiatrist should be judged only at the time of the violence, so once the patient was discharged into the community; any responsibility on the part of the psychiatrist was absolved.

[138] *Hill v Chief Constable of West Yorkshire Police* [1989] AC 53.

[139] At 62.

[140] At 62.

[141] Schopp and Quattrocchi, above n 131, at 18. See also Linn Turner Greenberg "The evolution of *Tarasoff*: recent developments in the psychiatrist's duties to warn potential victims, protect the public, and predict dangerousness" (1984) 12 J Psychiatry & L 315 at 317.

[142] At [162].

the legal power to control Ellis; only the ability to make an application in order to obtain this power under the MH(CA&T)A.[143] Thus, the DHB asserted that if they did not have the legal power to control Ellis, then they could not have had a duty to control him.[144] Potter J, however, thought that a special relationship could not be predicated on voluntary or compulsory status, due to the fact that psychiatrists can make applications under the MH(CA&T)A that may result in voluntary patients becoming subject to compulsory treatment orders (CTOs).[145] Thus actual control, or the ability to assert control (as with voluntary patients) will both make a duty more likely.[146] Despite this, Potter J went on to find that there was no proximity between the DHB and Ellis, because he was a voluntary patient.[147]

3. Summary on the relationship between psychiatrist and patient

A psychiatrist has professional training that gives them the "peculiar ability" to influence the conduct of the patient, and to potentially reduce the risk of harm to others. There will certainly be a special relationship where the patient is a compulsory inpatient. However, the approach taken in *Ellis* is more sensible than always requiring custodial control. As well as voluntary patients being subject to compulsory commitment, patients on community treatment orders (CommTOs) can be compelled to attend appointments and pulled back into hospital on short notice.[148] Thus, it is likely that the ability to assert control will be enough for a special relationship. Where there is no ability to assert control, because, for example, the patient is clearly non-committable because they do not fulfill the definition of "mental disorder", a duty will not attach.[149]

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[143] At [146].
[144] At [146].
[145] At [111].
[146] At [163].
[147] At [167]. It may be that Potter J concluded that Ellis was not a committable patient at the time of the attack, and so the DHB did not have the ability to assert control.
[148] See MH(CA&T)A, s 29. See Sylvia Bell and Warren Brookbanks *Mental Health Law in New Zealand* (2nd ed, Brookers, Wellington, 2005), Chapter 9: Community Care, for a full account of community treatment orders.
[149] A voluntary patient may be potentially violent and thus a danger to others, but not actually have an abnormal state of mind "characterised by delusions, or by disorders of mood or perception or volition or cognition". See MH(CA&T)A, s 2.

C. Relationship Between Psychiatrist and Potential Victim

This section looks at the *Couch* requirement that a potential victim be a member of an identifiable and sufficiently delineated class at a distinct and special risk.[150] The issue is *how* identifiable and delineated a class will need to be, before a duty to protect arises.

1. New Zealand authorities

The cases of *Van de Wetering*, *Maulolo*, *Midcentral*, *Ellis* and *Couch* have been outlined. This section will discuss their proximity arguments.

(a) *Van de Wetering*

Here there was no unique or pre-existing relationship between the DHB and the plaintiffs,[151] and the DHB had not voluntarily assumed responsibility towards the plaintiffs simply because it was treating someone they knew.[152] Nor did the relevant statutes create a relationship between the DHB and the plaintiffs.[153] Master Thomson said that to impose a duty would create "liability in an indeterminate amount for an indeterminate time to an indeterminate class",[154] and thus the proximity requirement could not be satisfied.[155]

(b) *Maulolo*

Master Thomson repeated the requirement for a "close and direct" relationship between plaintiff and defendant, but added that the defendant must have the power to

[150] *Couch* also says that individuals at a distinct and special risk will be proximate, but cases where there is an identified individual will be less controversial, as the only issue will be whether the risk was distinct and special. Thus the focus in this dissertation will largely be on sufficiently delineated classes.
[151] *Van de Wetering*, above n 16, at 9.
[152] At 9.
[153] At 10.
[154] At 10. As stated above at n 18, the duty in *Van de Wetering* was pleaded as a duty owed to all members of the public.
[155] At 9.

control the behaviour of the patient.[156] It was conceded that the DHB did not know the plaintiffs or the deceased woman, as Parr and Maulolo had not formed a relationship until after his release from inpatient care.[157] The plaintiffs did not allege that the defendant knew or ought to have known that the patient was a danger to an identifiable potential victim, as Parr had not expressed any intention to injure or kill anyone.[158] The fact that there had been a gap of one year between the patient's release and the murder was a telling factor against proximity.[159]

Wild J in his review said that it was impossible to distinguish the plaintiffs from the general public.[160] He noted that the situation in *Tarasoff* had been different, as there the deceased was known to be a threatened victim.[161] Wild J also considered *Palmer v Tees Health Authority*,[162] where it was recognised that the ability of the defendant to warn an identifiable victim (as opposed to an indeterminate class of people) was important in deciding on sufficient proximity.[163] Here, the defendant would have had no way to warn the plaintiffs.

(c) *Midcentral*

William Young J said that where a plaintiff sues a defendant for the actions of a third party, meritorious claims usually involve a pre-existing relationship between defendant and plaintiff or the defendant knowing that the third party posed "a particular threat to a particular individual or small group of individuals".[164] William Young J said that P had been subject to an inpatient order at all times, and so the DHB did have control over him.[165]

Although there was a pre-existing relationship between the defendant DHB and the victim, the case was decided on the basis that the plaintiff may be able to prove that

[156] *Maulolo*, above n 26, at [9].
[157] At [15].
[158] At [15].
[159] At [13].
[160] *Maulolo*, above n 31, at [23].
[161] At [26].
[162] *Palmer v Tees Health Authority* [2000] PNLR 87.
[163] At [30].
[164] *Midcentral*, above n 33, at [22].
[165] At [28].

the DHB "knew or ought to have known that P was a particular danger to female patients."[166] P did have a long history of inappropriate sexual behaviour towards women,[167] and William Young J found that there was sufficient proximity.[168] He stated that it was "pretty obvious" that the defendant owed a duty of care to female outpatients to protect them from harm at the hands of dangerous sexual predators who attended the same outpatient service.[169] Psychiatrists may therefore be found to owe a duty to potential victims of another narrow class like "other female patients of the outpatient service", even when there is no pre-existing relationship between psychiatrist and victim.

(d) *Ellis*

Potter J listed several features of the MH(CA&T)A that she thought pointed away from a finding of proximity between patient and DHB.[170] These included the purpose of the Act being to treat patients in the least restrictive environment; no statutory duties on clinicians to detain patients; and the various reviews and checks on the compulsory assessment and treatment procedure. Potter J concluded that there was insufficient proximity between Ellis and the DHB.[171]

(e) Majority and minority in *Couch*

The minority in *Couch* preferred a more expansive view and disliked the restrictive majority test for proximity. However, when it comes to the issue of liability for the behaviour of third parties, the principles laid down by the majority are very helpful. It is difficult to decide whether a potential victim is a "neighbour" to a psychiatrist,[172]

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[166] At [43]. This test is similar to the test later formulated in *Couch*, above n 10, at [112].
[167] At [12].
[168] At [48].
[169] At [45].
[170] *Ellis*, above n 40, at [166].
[171] At [167]. See also the discussion above in Chapter 4, B, 2, where *Ellis* was considered in relation to special relationships. The absence of a special relationship between Ellis and the DHB was another factor counting against proximity.
[172] See *Donoghue v Stevenson* [1932] AC 562 at 580 per Lord Atkin: "You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who then in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in

but it is somewhat less challenging to decide if a potential victim is part of a sufficiently delineated class. The principle formulated by the majority may promote consistency between decisions in this developing area of law. Furthermore, the minority's view could result in more expansive liability for psychiatrists, due to the lack of restraining guidelines.

(f) Summary on New Zealand authorities

All of these cases, bar *Midcentral* and *Couch*, failed to find sufficient proximity. No duty will be owed when the plaintiff cannot differentiate themselves from the general public, as was the case in *Van de Wetering* and *Maulolo*. *Ellis* decided that the DHB did not owe a duty to a patient to detain him, finding that his voluntary status,[173] as well as the statutory background, pointed away from a finding of proximity.[174] *Midcentral* gives the sole example of a probable "sufficiently delineated class" in the psychiatric context, that of "other female patients of an outpatient service".[175] However, some classes that do not involve a pre-existing relationship will also likely be found "sufficiently delineated".

2. Overseas authorities

A class may be formulated in fairly broad terms, as in *Smith v Jones*,[176] where the majority said that "little girls under five living in a specific area" would be a sufficiently identifiable group.[177] Lord Pill in *Palmer* said:[178]

> I see force in the submission that the question whether the identity of a victim is known ought not to determine whether the proximity test is passed. It is forcefully argued that

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contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question."

[173] And, presumably, the fact that he was not committable at the time.

[174] In this dissertation, the statutory background is considered in the policy inquiry, but it will be noted where a statute provides support for proximity.

[175] *Midcentral*, above n 33, at [45]. *Midcentral* was decided before *Couch*, but it is likely that the class recognised in *Midcentral* would have fulfilled the criteria proposed in *Couch*.

[176] *Smith v Jones* [1999] 1 SCR 455.

[177] At [68].

[178] *Palmer*, above n 162, at 108. This point did not arise to be determined on the facts in that case.

> the difference between the threat "I will kill X" and the threat "I will kill the first bald-headed man I meet" ought not to determine whether a duty is placed upon a defendant…"

In *Jablonski v United States*, it was held that a patient's history of violence towards a specific victim or class of victims may be enough to make that person or class of people identifiable, without any specific threats being made towards them.[179]

Identifiability may also be formulated more narrowly. In *Hill*, Lord Keith stated that the deceased could not be considered a member of a class at special risk simply because she was young and female.[180] In *Mavroudis v Superior Court*, it was held that while the potential victim need not be named by the patient, they must be readily identifiable at a "moment's reflection" in order to be owed a duty.[181] In *Thompson v County of Alameda*, the majority judgment said that where a threat is not made to a "named or readily identifiable victim or group of victims who can be effectively warned of the danger", no duty of care would be imposed.[182]

In America, at least 22 states have legislated in order to define the *Tarasoff* duty.[183] Most of them limit the duty to when the patient has made a threat about a named or clearly identifiable victim, or when the patient has a history of violence and the therapist should know that serious violence might be committed.[184]

Of the overseas cases, even the more narrow ones have not defined identifiability as being limited to named potential victims where a clear threat has been made. Identifiable potential victims therefore may include specific groups of people not named by the patient and not the subject of any threats, but towards whom the patient may have a history of violence. This is largely similar to the statutory formulation in the majority of American statutes.

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[179] *Jablonski v United States* 712 F 2d 398 (1983) at 398 as cited in Damon Walcott, Pat Cerundolo and James Beck "Current Analysis of the Tarasoff Duty: an Evolution towards the Limitation of the Duty to Protect" (2001) 19 Behav Sci & L 325 at 329.
[180] *Hill*, above n 138, at 62.
[181] *Mavroudis v Superior Court of San Mateo* 102 Cal App 3d (1980) at 600.
[182] *Thompson v County of Alameda* 614 P 2d 728 (Cal 1980) at 758.
[183] Walcott, Cerundolo and Beck, above n 179, at 339 and Appendix.
[184] Walcott, Cerundolo and Beck, above n 179, at 339.

3. Criteria for proximity: actual ability to warn

It is contended that the key criteria for sufficient proximity between psychiatrists and potential victims is that the potential victim must *always* be sufficiently identifiable so that the psychiatrist could theoretically warn them.[185] The importance of this is that if a duty is imposed as soon as a psychiatrist believes that a patient may act violently, but when the potential object of this violence is not obvious, the over-detention of patients will be encouraged because no one could be warned. A patient may be committed when, if the psychiatrist did not have to worry about liability, they would have been discharged.

The requirement of an actual ability to warn must be viewed in a practical sense. While a psychiatrist could conceivably phone and warn every female in North Dunedin that a dangerous patient had expressed threats about raping women, or try to put out a warning via radio, it would be unreasonable to place liability on a psychiatrist for failing to do this. Thus the idea of being able to warn must be understood against the background of narrow liability and the desire to avoid excessive warnings.

4. Hypothetical classes

As discussed above, judges have supported classes such as "little girls under five living in a specific area" and "the first bald-headed man I meet" as being sufficiently delineated. In *Jane Doe*,[186] a rapist had been operating in Toronto, targeting young women who lived alone in apartments with balconies near a particular intersection. It was held that the police owed a duty of care towards the fifth victim of the rapist, as they should have issued a warning to this clearly defined class of women, who could have then taken steps to protect themselves.[187]

[185] This idea was discussed in *Palmer*, above n 162, at 100. The court recognised the importance of the ability of the defendant to warn an identifiable victim.
[186] *Jane Doe v Metropolitan Toronto (Municipality) Commissioner of Police* (1998) 160 DLR (4th) 697 (Ontario Court of Justice, General Division).
[187] At [158], [183] and [185].

It might be that the combined dimensions of gender, age and location will merit a sufficiently delineated class, or that people with certain physical characteristics would be acceptable. The gender/age/location class would only be workable when narrowly defined, such as "females under the age of five living on X Street, or in the neighbourhood bordered by X, Y and Z streets". The class of "young females living in Dunedin" will clearly be unworkable when it comes to actually being able to warn. A geographical location will often be important, but the specificity required may depend on the relevant personal characteristics of the potential victims. For example, in a class defined by the characteristic of "being Chinese", a location of Auckland will be far too broad. However, a class of "all Chinese people living in Mataura" may well be sufficiently delineated. An alternative (or additional) parameter to a geographical location may be a particular relation between the potential victims, such as employees of a particular company, or members of a particular church. Again, this would need to be narrow enough so that the psychiatrist could warn each member, so while "the congregation of the Sacred Heart church of Dunedin" could be a sufficiently delineated class, "Catholics in Dunedin" will not be.

D. The Threat

As well as being part of a sufficiently delineated group, the potential victim has to be at a distinct and special risk. Distinct means that the risk must be clearly apparent, and special means that the "plaintiff's individual circumstances, or her membership of the necessary class rendered her particularly vulnerable to suffering harm of the relevant kind".[188] As discussed above, frequent physical proximity will not be enough for a risk to be "special". The "special" element relates to the identifiability of a potential victim, as being part of a sufficiently delineated class may bring with it risk of harm of a particular kind. In *Couch* it was also said that the characteristics of the wrongdoer themselves will be relevant, so that whether a risk is "special" will depend upon a combination of the potential victim's membership of a sufficiently delineated class along with matters relating to the wrongdoer, such as their modus operandi.[189]

As for the "distinct" requirement, *Couch* makes it clear that there does not need to be

[188] *Couch*, above n 10, at [112].
[189] At [120].

any explicit threat made by the patient – instead, a history of violence towards a particular victim or class of victims will be enough to trigger a duty to protect.

Regarding the seriousness of the threat, in *Tarasoff*, the threat level required was described as "serious danger of violence to another".[190] *Smith v Jones* went further and required that it be a threat of "serious bodily harm or death", but it was held that serious psychological harm might constitute serious bodily harm.[191] In any case, it is clear that, before a duty will be imposed upon a psychiatrist, they will need to be aware that there is some kind of serious threat to the potential victim, whether through threats made by the patient or through a history of violence. It is likely that a duty will be imposed before the level of violence threatened is fatal, as it can be a fine line between fatal and non-fatal violence.

E. Summary

It is probable that a special relationship between a psychiatrist and their patient will be found, for these purposes, where the patient is voluntary but within the committal criteria at the time, on a CommTO or on a CTO. The issue of an identifiable and sufficiently delineated class is related to the ability of the psychiatrist to actually give warnings, and so potential victims will need to fall within a narrowly defined class. The patient does not need to have actually made threats in order for a duty to arise, as a history of serious violence towards an individual or a particular class will be enough. These requirements place significant limits on the ambit of a duty to protect.

[190] *Tarasoff*, above n 6, at 431.
[191] *Smith v Jones*, above n 176, at [83].

Chapter 5: The Policy Inquiry

The policy inquiry aims to determine whether it will be "fair, just and reasonable" to impose a duty on one party towards another in a novel situation. This chapter will be split into two sections. It will first consider policies that have been endorsed by Parliament through being embedded in the relevant legislation. It will then discuss other policy factors, and in the end reach a view of where the total policy considerations might point regarding psychiatrists' duty to protect.

I. The Statutory Background

Courts want to ensure that a common law duty of care does not undermine the aims of Parliament.[192] The principles of how the statutory background affects the negligence liability of public authorities were discussed in the general principles chapter. These principles are relevant to psychiatrists in New Zealand, who are generally employed by public authorities. This chapter examines a number of core New Zealand statutes applicable to the work of psychiatrists, or to analogous contexts where risks of harm exist, in light of these principles, in order to see whether there is support for a common law duty.

A. The Policy Embedded in Particular Statutes

1. Mental Health (Compulsory Assessment & Treatment) Act 1992

This Act is relevant to the discharge of the duty to protect via detention of the patient. Its long title says that it is an Act to define the rights of patients and provide better protection for those rights. It does not mention public safety. However it is implicit in the definition of "mental disorder" in section 2 of the Act that protection of the public is one of its aims. A person will be mentally disordered if they have an abnormal state of mind and they "[pose] a serious danger to the health or safety of [themselves] or of

[192] Booth and Squires, above n 93, at 167.

others".[193] If a patient fulfils those criteria, they may become subject to a CTO.[194] The Court may also declare inpatients to be "restricted patients" if they present special difficulties due to the danger that they pose to others.[195] Thus, the Act does aim to reduce the risk of harm to the public. These sections may therefore support there being sufficient proximity between psychiatrists and potential victims.

Section 4 states that a person cannot become subject to compulsory treatment only by reason of, for example, their sexual preferences, criminal or delinquent behaviour or substance abuse, where they are not mentally disordered. Thus psychiatrists cannot legally commit a patient who is not mentally disordered simply because they are threatening to kill a person.[196] During the passage of the MH(CA&T) Bill, the Minister stated that "the legislation looks to assess and to treat patients in the least restrictive environment".[197] A major component of this was the new CommTO.[198]

The dual aims of the Act to both protect patients' rights and to protect the public may therefore conflict at times, if a person who poses a risk to others must be released from compulsion when no longer mentally disordered. In *South Pacific Manufacturing*, Cooke P thought that a private investigator could simultaneously owe a duty to the insurance company and the insured party in an arson investigation with no conflict of interest.[199] However, in *Van de Wetering*, Master Thomson said:[200]

> [i]t would be highly dangerous, and inconsistent with the purpose of the legislation […] for the clinician to be even put in the position of possibly being influenced, consciously or unconsciously, by the risk of legal liability to individual members of the public for

[193] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2. An "abnormal state of mind" is characterized by, whether of a continuous or intermittent nature, delusions or disorders of mood, perception, volition or cognition.
[194] See Bell and Brookbanks, above n 148, Chapter 8: The Committal Process, for a full account of the committal process in New Zealand.
[195] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 55. This means that the patient is subject to further limitations, such as requiring the consent of the Minister of Health for a leave of absence longer than seven days (s 50).
[196] The decision of *Waitemata Health v A-G* [2001] NZFLR 1122 reinforces this, deciding that a person cannot be subject to a compulsory treatment order unless they are mentally disordered.
[197] (2 June 1992) 525 NZPD 8455 per the Hon Katherine O'Regan.
[198] (2 June 1992) 525 NZPD 8455. See MH(CA&T)A, s 29.
[199] *South Pacific Manufacturing*, above n 61, at 301 per Cooke P.
[200] *Van de Wetering*, above n 16, at 16.

failing to seek [a CTO].

A duty to protect potential victims could result in over-detention of patients, including those who are not mentally disordered or have ceased to be so. This is especially a risk if psychiatrists would face liability even when they do not know the identity of a potential victim, but fear that the patient will generally be a danger if released. However, if, as discussed above, a duty of care only arises when the class of potential victims is sufficiently delineated so that the psychiatrist could actually warn them, the risk of over-detention is reduced. The psychiatrist could discharge the duty by giving warnings rather than detaining patients, if detention was not clinically indicated.

Therefore, in relation to the MH(CA&T)A, the imposition of a common law duty of care certainly has the potential to produce a conflict of duties.[201] However, imposing a duty only to a strictly defined class of people can largely mitigate this risk.

2. New Zealand Bill of Rights Act 1990

The New Zealand Bill of Rights Act supports the patients' rights aims of the MH(CA&T)A as it gives people the right not to be arbitrarily detained.[202] Therefore, there are strong human rights principles supporting the requirement not to detain anyone who is not "mentally disordered".

3. Health Information Privacy Code 1994 (HIPC)

This Code is relevant to the discharge of the duty to protect through warning. Rule 11(2)(d) of the HIPC provides a discretion (not a duty) for a health agency[203] to disclose private information about a patient. The decision whether to exercise that

[201] For an example, see *Hunter Area Health Service v Presland* [2005] NSWCA 33, where it was found that no duty to detain was owed to a patient who had killed his brother's fiancée after being released. At [378], Santow JA said that if a decision not to detain could result in negligence liability, a decision to detain could also be challenged. This would distort the discretion in a way that would be contrary to the purpose of the Australian statutory scheme.
[202] At s 22.
[203] A term that includes all health professionals.

discretion should be made in accordance with the relevant ethical standards and only where the health agency feels that disclosure is necessary.[204]

Rule 11(1) of the HIPC sets out the presumption that health information must not be disclosed without the patient's consent. Rule 11(2) goes on to say that compliance with subsection (1) will not be necessary if "the health agency believes on reasonable grounds that it is either not desirable or not practicable to obtain authorisation from the individual concerned", and one of the listed circumstances is met.[205] Rule 11(2)(d) provides that one of the circumstances is where:

> the disclosure of the information is necessary to prevent or lessen a serious threat to—
> (i) public health or public safety; or
> (ii) the life or health of the individual concerned or another individual.

Rule 11(3) states that disclosure under subsection (2) is only permitted to the extent necessary for the particular purpose.

Until April 2013,[206] Rule 11(2)(d) read slightly differently, permitting a disclosure to be made where necessary to prevent or lessen a "serious and imminent" threat. The word "imminent" was removed in order to bring the HIPC into line with changes made in the Privacy Amendment Act 2013. During the passing of this Bill, it was said that it took a "practical view" in the area of mental health, because:[207]

> people have inadvertently made decisions about the protection of privacy of information that have actually resulted in people being put at risk and people being hurt inappropriately. […] while there is a proper respect for privacy, that needs to be balanced with other public interests and public goods such as the protection of safety...

[204] John Dawson "Privacy and Disclosure of Health Information" in Peter Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) 269 at 278.
[205] See Dawson, above n 204, at 301. Situations where it is "not practicable" to obtain authorisation include where the individual's consent has been sought but not given.
[206] The date that the Health Information Privacy Code 1994 Amendment Code No 7 (18 March 2013) came into force.
[207] (19 February 2013) 687 NZPD 7943 per the Hon Nick Smith.

The Hon Judith Collins stated that removing the requirement for the threat to be "imminent" would allow Government agencies to share information at an earlier stage.[208] She said, "[the] difference between a serious threat and an imminent threat can be crucial, particularly when we are dealing with vulnerable people."[209]

However, the definition of "serious threat" in section 4 of the Privacy Amendment Act 2013 states that:

> serious threat […] means a threat that an agency reasonably believes to be a serious threat having regard to all of the following:
> (a) the likelihood of the threat being realised; and
> (b) the severity of the consequences if the threat is realised; and
> (c) the time at which the threat may be realised.

The third element of time indicates that "imminence" remains part of the inquiry into seriousness.[210]

Nevertheless it is clear that Parliament intended to make information sharing easier.[211] The overall theme is protection of the public, with a reduction in the importance of privacy. It aims to protect "vulnerable people", and potential victims of violent psychiatric patients fall into that category. Comments on the Bill in Parliament indicate the mental health context was at the forefront of the minds of MPs.[212]

The proximity inquiry discussed above placed importance on the actual ability of the psychiatrist to warn potential victims. This restriction is supported here, because

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[208] (12 February 2013) 687 NZPD 7756.
[209] (12 February 2013) 687 NZPD 7756.
[210] The requirement of serious danger has been extensively discussed in case law in relation to the definition of "mental disorder" under the MH(CA&T)A. Several components are assessed, including the nature and magnitude of the harm, imminence, frequency and the likelihood of the harm occurring. Thus Parliament's definition of a serious threat under the Privacy Amendment Act 2013 may have been informed by this. See Warren Brookbanks "Mental Health Law" in Peter Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) 357 at 369.
[211] It appears that an important impetus for the change was addressing situations where poor cooperation between agencies such as CYFS and the police results in child abuse going unchecked.
[212] See comments made by the Hon Nick Smith, above n 207, at 7943.

expansive liability would conflict with the HIPC. The discretion to disclose that it confers is an exception to a general prohibition, and disclosure is only permitted to the extent necessary for the particular purpose and in strictly defined situations. This indicates that any common law duty that requires disclosure to a large number of people will undermine the policies in the Code. In contrast, a common law duty of care based on a narrow definition of proximity is less likely to conflict with the Code, and could even be supported by it.

The final consideration in relation to the discretion under the HIPC is that it is not easy to turn a statutory "may" into a common law "ought".[213] Imposing a duty to protect on psychiatrists would not be a straightforward case of turning the HIPC discretion to disclose into a duty to do so, as a duty to protect is a wider concept and encompasses detention as well as warning. Nevertheless, the fact that the Code confers only a discretion indicates that there will need to be something extra before a common law duty would be appropriate. Lord Reid in *Dorset Yacht* suggested that if a discretion was exercised so unreasonably that it was not really exercised at all, a common law claim in negligence may lie.[214] Therefore, where a psychiatrist has omitted to disclose information in a situation where not disclosing was so unreasonable that they did not really exercise the discretion at all, a common law duty might be imposed. An example of this would be where the psychiatrist knew the identity of the potential victim or class of victims, knew that the patient intended to cause harm to the potential victim, and knew there was a high chance it would happen (i.e., through the patient's history of violence).

4. Victims' Rights Act 2002

This statute is relevant to the discharge of the duty to protect through warning. Section 37 states that if an offender who is compulsorily detained in a hospital or a facility is being discharged or granted leave of absence, a registered victim must be given reasonable prior notice of this. Similarly, if such an offender has escaped or died, the victim must be given notice as soon as practicable.

[213] See *Stovin v Wise*, above n 69, at 948.
[214] *Dorset Yacht Company*, above n 112, at 1031.

The purpose of the duty to disclose under section 37 is to enhance the safety of victims. It is clear from Parliamentary debates at the time of passing the Victims' Rights Act that an important aspect of the legislation was expanding the number of victims who had the right to be notified about the offender.[215] More recently, the Victims of Crime Reform Bill[216] has been before Parliament, having its first reading in late 2011. Again, the debates indicate Parliament intends to move towards greater rights for victims, as the Bill would widen the eligibility of victims who can receive notice and expands the information such victims can receive.[217]

A duty will be more readily imposed if it would not require a public authority to act any differently.[218] In this case, imposing a common law duty to protect potential victims would require similar action to that already required under section 37. One aspect of protecting potential victims is warning them of the danger posed by the patient, and this is like the notification given to victims. Thus it is unlikely that a common law duty to potential victims would conflict with the statutory duty to notify prior victims.

Section 50 of the Act states that no person can be required to pay money to another person because of a breach of the provisions of the Act. This does not preclude the development of a common law duty to protect potential victims, but it may count against it. However, it is a serious matter when a patient physically injures a person and a psychiatrist with knowledge of the danger failed to warn or otherwise avert the tragedy. While Parliament intended to protect the Crown from paying damages if it did not properly carry out its statutory duties under the Act, it probably did not intend to confer immunity upon those who have knowledge of danger and a statutory duty to notify, but do nothing to avert it. Therefore it is unlikely that this exclusionary provision will impact upon the recognition of a parallel common law duty of care.

As discussed above, if there has been a physical injury to the plaintiff as a result of a public authority's unreasonableness, it is more likely that a duty of care will be

[215] (8 October 2002) 603 NZPD 1315.
[216] Victims of Crime Reform Bill 2011 (319-2).
[217] (4 October 2011) 676 NZPD 21685.
[218] *Stovin v Wise*, above n 69, at 935.

imposed. This view is supported by the broad goal behind the Victims' Rights Act 2002 and the Victims of Crimes Bill – that victims should be protected from dangerous members of society. The fact that the new Bill aims to further expand the rights of prior victims means that it is likely that a common law duty towards potential victims would not conflict with Parliament's intent in this area.

5. Land Transport Act 1998

This statute relates to the acceptability of warning potential victims. Section 18 says that a medical practitioner who considers a driver should not be permitted to drive due to their mental or physical condition must give the Land Transport Agency notice of this as soon as practicable. Section 18(3) provides that there will be no civil or professional liability following such a disclosure unless the information was given in bad faith. Parliament is indicating here that when it comes to people with mental health issues posing a danger, public safety will take precedence over privacy concerns.

6. Children, Young Persons and their Families Act 1989 (CYPFA)

Again, this statute relates to the discharge of the duty through warning. Section 15 allows "any person" to report to a social worker or constable when they believe that any child or young person "has been, or is likely to be, harmed (whether physically, emotionally, or sexually), ill-treated, abused, neglected, or deprived…". Section 16 provides that a person who does report will not be subject to any civil, criminal or disciplinary proceedings, unless they acted in bad faith. This Act is therefore another example of Parliament indicating that the interests of victims or potential victims will take precedence over privacy.

7. Health Practitioners Competence Assurance Act 2003

Section 100(1) provides that a health practitioner may be found guilty of professional misconduct if the Tribunal believes that any acts or omissions have amounted to negligence. In *South Pacific Manufacturing*, the court decided that because the statute provided for disciplinary measures to be taken when private investigators were

negligent, the imposition of a common law duty of care was strongly supported.[219] The same conclusion may not be so readily reached here. It is clear that psychiatrists owe a duty of care towards their patients, which is analogous to an investigator owing a duty of care to an investigated party. However, it is unlikely that section 100 tells us anything about the imposition of a duty of care in respect of omissions in relation to third parties.

Indeed, the Act may be seen as providing an alternative remedy, as it gives another way of encouraging health professionals to behave. As discussed above, statutory remedies can be seen as precluding tortious liability. However, it is improbable that a physical injury to a victim will be seen as adequately compensated by professional disciplinary consequences for the psychiatrist. Therefore s 100 provides no strong guidance on the imposition of a duty.

8. Accident Compensation Act 2001

Section 317 of this Act places a bar on tortious action being pursued in respect of personal injuries. In *Couch*, Susan Couch was already getting paid compensation, and perhaps this is enough.[220] However, section 319 explicitly preserves the ability to sue for exemplary damages, indicating that Parliament felt that statutory compensation would not adequately redress victims where there was gross negligence. Section 317 also implicitly recognises the existence of duties in relation to personal injuries; it simply states that damages will not be paid in recognition of their breach. Aggrieved victims can still sue and obtain a declaration that the defendant was guilty of negligence. Therefore it is likely that the existence of ACC compensation will be neutral on whether a common law duty should be imposed.

B. Summary on Statutory Policy Arguments

The MH(CA&T)A is at risk of being undermined by the imposition of a common law duty. A requirement to protect potential victims may lead to over-detention of patients

[219] *South Pacific Manufacturing*, above n 61, at 298 per Cooke P.
[220] See *Couch*, above n 10, at [25]. The minority in *Couch* referred to this argument as made by William Young P in *Hobson v Attorney-General* [2007] 1 NZLR 374 at [127].

if expansive liability is imposed on psychiatrists. However, this risk will be alleviated by a strict definition of when a potential victim will be "proximate".

The HIPC and the recent change to it indicates the general policy of Parliament that privacy interests will have to give way to public safety in some situations. However, an expansive duty of care would still undermine the general scheme of the Code, which is to confer a limited discretion to disclose. Again, a strict definition of proximity will avoid undermining this. It will also take a high level of unreasonableness in the exercise of the discretion before a common law "ought" will be imposed.

The Victims' Rights Act indicates Parliament's general policy, by giving the right to be notified to prior victims. The focus on "arming" victims with knowledge is strengthened in the new Bill. The Land Transport Act and the CYPFA both offer support for the protection of the public being elevated over the privacy concerns of the individual. The Health Practitioners' Competence Assurance Act provision for disciplinary action in the case of negligence is probably neutral on a common law duty of care, as is the Accident Compensation Act.

In sum, the statutory background does not strongly support the imposition of a duty to protect. However, if liability is hemmed in by a strict definition of sufficient proximity between plaintiff and defendant, then it can be said that the statutory background does not conflict with the imposition of a duty. Furthermore, the clear policy of Parliament to subjugate privacy interests in favour of public safety in certain situations shows that there is at least some support for such a duty in the legislation.

II. Other Policy Considerations

Beyond the policy considerations embedded in the statutes, there are other policy arguments that may point against or support the imposition of a duty to protect being imposed upon psychiatrists.

A. The Difficulty of Predicting Violence

1. The problem

In order for psychiatrists to be liable for negligently failing to protect potential victims, they should first be able to accurately predict future violence. It is likely that many more psychiatric patients make threats than those who actually carry through. In the *Tarasoff* decision, the American Psychiatric Association argued as amicus curiae that research showed there was no ability on the part of mental health professionals to predict incidents of violence reliably.[221] The court in *Tarasoff* declared that therapists would only be held to the standard of a member of their profession who was exercising reasonable skill, knowledge and care.[222] Arguably, this made no sense when there was little likelihood that *any* member of the profession could predict violence.[223] One study by Robert Menzies et al. found that lay people were actually better at predicting later violence in patients than clinical therapists.[224] A study by Lidz et al. was slightly more positive, finding that clinicians managed to pick out a group of patients who were statistically more violent and whose acts were more seriously violent than the acts of a comparison group.[225] However, the clinicians were still "relatively inaccurate predictors of violence".[226] Several policy arguments stem from this inability to predict violence, and some of these will now be outlined.

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[221] *Tarasoff*, above n 6, at 437.
[222] *Tarasoff*, above n 6, at 431.
[223] See Lance Egley "Defining the *Tarasoff* duty" (1991) 19 J Psychiatry & L 99 at 105; Greenberg, above n 141, at 337.
[224] Robert Menzies, Christopher Webster, Shelley McMain, Shauna Staley, and Rosemary Scaglione "The Dimensions of Dangerousness Revisited: Assessing Forensic Predictions About Violence" (1994) 18 Law and Human Behaviour 1 at 19.
[225] Charles Lidz, Edward Mulvey and William Gardner "The Accuracy of Predictions of Violence to Others" (1993) 269 JAMA 1007 at 1009.
[226] At 1010.

2. A duty only imposed once violence is predicted

In the wake of *Tarasoff*, concern was expressed about the objective standard of a member of the profession who was exercising reasonable skill, knowledge and care.[227] Mosk J, dissenting in *Tarasoff*, thought that the reference to what psychiatrists "should determine"[228] ought to be removed, so that psychiatrists only had to exercise reasonable care if they did in fact predict violence.[229] In relation to professional standards, he said:[230]

> The question is, what standards? Defendants and a responsible amicus curiae, supported by an impressive body of literature […] demonstrate that psychiatric predictions of violence are inherently unreliable.

Thus, on Mosk J's view, the requirement for reasonable care would only apply to the steps taken in attempting to avert the predicted violence. Indeed, this is the approach taken in the American statutes that have since codified the *Tarasoff* duty.[231] However, there are three problems with this version of a duty to protect.

(a) Distinguishing between "did" and "ought to"

Mosk J's formulation of a duty to protect distinguishes between an inquiry into whether the psychiatrist did in fact predict violence and an inquiry into whether the psychiatrist ought to have predicted violence.[232] This is unlikely to be straightforward. In the absence of hard evidence (e.g., clinical notes) on whether a psychiatrist predicted violence, a court would only have the evidence of the psychiatrist (which

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[227] See *Tarasoff*, above n 6, at 431.
[228] The principle from *Tarasoff*, above n 6, at 431 was: "When a therapist determines, *or pursuant to the standards of his profession should determine*, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger." (emphasis added).
[229] As was the case in *Tarasoff*, where the psychologist had tried to get Poddar taken into custody as a result of his prediction of violence.
[230] Tarasoff, above n 6, at 451.
[231] See Walcott, Cerundolo and Beck, above n 179, at 339. Therapists' liability in the statutes is generally limited to actions taken in discharging the duty, thus ruling out liability for omitting to warn or detain at all.
[232] Colin Gavaghan "A *Tarasoff* for Europe? A European Human Rights perspective on the duty to protect" (2007) 30 Int'l JL & Psychiatry 255 at 263.

may be self-interested and deny that any prediction was made), or no evidence on the matter. Therefore, they would have to decide whether to accept the psychiatrist's evidence or impute a prediction to them, based upon what a reasonable psychiatrist would have done in the circumstances. This would be using an objective standard, conflating the questions of whether a psychiatrist "did" or "ought to" have predicted violence.

(b) Disincentive to good practice

Having a duty to protect that only applies to psychiatrists who in fact predict violence would be a disincentive to good practice. Psychiatrists may consciously ignore warning signs, knowing that they will not be liable for failure to prevent violence if they remain apparently unaware. Furthermore, psychiatrists who act on warning signs and try to prevent the patient from becoming violent may choose not to record clinical notes regarding their prediction. After all, this would be creating evidence that may be used against them.

(c) The concept of "prediction"

Imposing a duty upon psychiatrists who have predicted violence presupposes that it can be determined when a "prediction" has been made. A psychiatrist may observe that there is a "small chance of X becoming violent", that "Y may become violent if provoked by his wife," or that there is a "high risk" of Z acting violently in the short-term. Whether any of these would count as "predictions of violence" would be a qualitative question for the court, and is by no means obvious.

Therefore, while a duty that takes into account what psychiatrists "should determine" appears foolish due to the inability to predict violence, a duty that is only concerned with what they in fact determined is also very problematic.

3. Prediction of violence in the context of narrow liability

The problem of predicting violence has diminished significance when only imposing a narrow form of liability.[233] A hypothetical case may involve a psychiatrist who failed to take action when a patient had expressed serious threats towards a specific individual or sufficiently delineated class over a short period before an attack happened. The patient may have had a history of violence towards that individual or class. In such a case, it is highly unlikely that a judge will be impressed by an argument that the psychiatrist could not have predicted such a thing. Psychiatrists may not have the ability to go through a list of their patients and accurately pick out who will commit some form of violence towards some person sometime. However, courts are likely to see them as having the ability to predict violence in short-term situations involving graphic violence, where there was an identifiable potential victim at a special and distinct risk.

4. Summary on the difficulty of predicting violence

Psychiatrists' inability to predict violence is a less significant policy factor against the imposition of a duty than it initially appears, provided liability arises only in limited circumstances. Moreover, the majority of cases will likely be brought against psychiatrists who did predict violence anyway, and took some steps to try and avert it. In these cases, the question will be whether a psychiatrist taking reasonable care to protect a potential victim would have done more.

B. Breaching Confidentiality Through Warning

Warning the potential victim is one way of discharging a duty to protect. In the wake of *Tarasoff*, there was alarm that a duty to warn would routinely require psychiatrists to breach confidence.[234] This section considers whether breaches of confidence for the

[233] See Vikram Mangalmurti "Psychotherapists' fear of *Tarasoff*: all in the mind?" (1994) 22 J Psychiatry & L 379 at 388.

[234] This may have stemmed from a widespread misunderstanding that the duty required therapists to warn in all cases, when in fact committal of the patient may sometimes be more appropriate.

purpose of avoiding negligence liability are likely to count against imposition of a duty.

1. The therapeutic alliance

There is concern that breaching confidence will lead to the destruction of the "therapeutic alliance" between psychiatrist and patient.[235] However, this issue is less significant in New Zealand than in America, where *Tarasoff* was decided. In America, there is a large private sector practising psychotherapy. In many instances, the recipients of these services will not be mentally ill but rather "the worried well". They are unlikely to be committable, and the therapist stands to lose a source of income through breaching confidentiality.

In contrast, in New Zealand there is less psychotherapy. Due to resource limitations, people seeing public sector psychiatrists in New Zealand are more likely to be seriously unwell, and may be committable if they start threatening violence. Furthermore, these people do not pay for their treatment – instead, the psychiatrist will be on a salary paid by their DHB. For patients receiving compulsory treatment under the MH(CA&T)A, there may never have been much of a "therapeutic alliance" to begin with, since treatment is being forced upon them.

Thus, while confidentiality is of course important to the psychiatrist-patient relationship, it is less likely to be seen as sacrosanct in New Zealand, and psychiatrists may be less concerned about the prospect of breaching it for the purpose of public safety. They are also more likely to have the alternative of committing the patient.

2. A self-defeating duty?

If there is a duty to breach confidence in some situations and patients know about this, they may begin to be less frank with their psychiatrists.[236] The effect of this will be that psychiatrists will know of fewer potential threats, and therefore have fewer

[235] See Stone, above n 135, at 368-369.
[236] Mangalmurti, above n 233, at 399. See also Stone, above n 135, at 369.

chances to avert them through therapy.[237] However, most therapy in New Zealand already begins with a confidentiality warning, and this is accepted as standard practice. Voluntary patients may still be candid despite such a warning because they want help.[238] Other patients may not take especial notice of the warning, or at least not have it in the forefront of their minds when they blurt out a threat later.

3. Precedents for disclosure in New Zealand

In New Zealand there is already a discretion to disclose information to third parties under Rule 11(2)(d) of the HIPC, discussed above. Furthermore, the Royal Australian and New Zealand College of Psychiatrists' Code of Ethics states in Principle 4.3 that confidentiality may be breached in rare situations where there is a clearly identifiable potential victim.[239] Thus it is not unprecedented for psychiatrists to breach confidence in order to warn a potential victim, whether or not a tort law duty is imposed.[240]

4. Giving the warning

Once a decision to warn a potential victim has been made, there are three further considerations.

(a) Warning to what extent?

The psychiatrist has to decide whom to warn and how much to divulge. In *Tarasoff*, the therapist had warned the campus police that Poddar was dangerous, but knew that he had not been detained. It was found that the therapist had not done enough – once he knew that Poddar had been released, he had a duty to take further action. This included warning Tarasoff or her family. If *Tarasoff* is accepted, the content of a duty

[237] Mangalmurti, above n 233, at 399.
[238] Mangalmurti, above n 233, at 399.
[239] The Royal Australian and New Zealand College of Psychiatrists *Code of Ethics* (RANZCP, Melbourne, 2010). Principle 4.3 in full: "A breach of confidentiality may be justified on rare occasions in order to promote the best interests and safety of the patient or of other people. Psychiatrists may have a duty to inform the intended victim/s and/or relevant authorities."
[240] See also *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 at 521, where it was recognized that confidentiality is not absolute, and doctors may breach it where "another's life is immediately endangered and urgent action is required".

to protect may require psychiatrists to warn multiple parties until satisfied that appropriate action had been taken.[241] This would require breaching confidence several times. In New Zealand, it may be that a judge faced with a similar factual situation to *Tarasoff* would conclude differently, and find that the duty would be discharged as soon as a warning was given to a party (or parties) that the psychiatrist reasonably believed would be able to prevent or lessen the threat.[242]

(b) The usefulness of warnings

A warning given to a potential victim has been argued to be unhelpful, and it could be more sensible for a psychiatrist to simply warn the police.[243] However, unless a crime such as threatening to kill or breach of a protection order has been committed, police will usually have no power to detain the patient. If the psychiatrist warns the potential victim of an immediate and serious risk, it is likely that they will be able to protect themselves. Such immediate and serious threats may be short-term, enabling patients to take action such as staying away from home. Therefore, warning the potential victim may be the most effective course of action.[244]

(c) Vigilante justice

There is a chance that warning a potential victim may lead to violence against the patient. Gavaghan states:[245]

> [t]he threat of 'vigilante' violence against patients – particularly, we might suppose, against those with paedophilic inclinations – is clearly not a trivial one, and protecting them from such is clearly another duty of which psychiatrists must take account.

[241] This issue is mostly relevant to what will count as "reasonable care", but it also has policy implications for the imposition of a duty.
[242] This approach is arguably supported by Rule 11(3) of the HIPC, which requires that disclosure be "only to the extent necessary for the particular purpose."
[243] Stone, above n 135, at 374. See also *Thompson*, above n 182, at 754, where it was said that a duty to warn would be "unwieldy and of little practical value", due to the "cacophony of warnings" that would have to be given.
[244] If, on the other hand, the patient poses a less serious but persistent risk, a warning may not be so useful. Here, the more appropriate action may be to commit the patient.
[245] Gavaghan, above n 232, at 264.

It is not hard to imagine a situation where a patient makes a threat against a former girlfriend who now has a new boyfriend. If warned by the psychiatrist, the new boyfriend may retaliate. However, this is unlikely to be a decisive factor against the imposition of a duty. It will mainly go to the standard of care required, and will be another consideration for the psychiatrist to weigh up when discharging the duty.

5. Summary on breaching confidentiality

A central consideration is that New Zealand law already provides a discretion to disclose information to third parties where there is a serious threat, and there is an ethical principle that confidentiality may be breached where there is a threat against an identifiable victim. Most psychiatrists routinely give a confidentiality warning at the start of therapy sessions. Thus psychiatrists are accustomed to breaching confidentiality where necessary. The uncertainties about the extent of warning required, to whom the warning should be given, and vigilante justice all arise in relation to the exercise of this discretion already, and they may therefore not be significant barriers to the strengthening of that discretion into a duty.

C. Defensive Practice

It is possible, however, that imposing a duty will encourage the practice of defensive medicine. Defensive practice occurs when doctors practise in a way that protects them from liability, but which may harm their patients.[246] This has been described as an attitude of "cautious self-protection".[247]

1. What is defensive practice?

Fanning lists some examples of defensive medicine, including prescribing more medications than are medically indicated; referring to specialists unnecessarily; suggesting invasive procedures against professional judgment; avoiding certain

[246] John Fanning "Uneasy lies the neck that wears a stethoscope: some observations on defensive medicine" (2008) 24(2) PN 93 at 93.
[247] Warren Brookbanks "Liability for discharged psychiatric patients" (2002) 5 NZLJ 199 at 200; *Maulolo*, above n 26, at 7.

procedures against professional judgment; and avoiding caring for high-risk patients altogether.[248] In the psychiatric context there is the danger of excessive caution in issuing certificates for assessment and treatment under the MH(CA&T)A,[249] over-detention of patients and reluctance to place inpatients on leave or a CommTO.[250] A study has also found that in the wake of *Tarasoff*, therapists tended to focus more on violence during therapy and tended to avoid treating potentially dangerous patients.[251]

In a Mental Health Commission review of the Privacy Act 1993 and the HIPC, it was noted that patients felt clinical staff acted defensively in relation to requests for information.[252] They saw the "focus of staff as being on protecting themselves", and it was concluded that "[c]linicians' fear of legal repercussions was seen by service users as a barrier to developing a collaborative relationship."[253] This was in the context of information disclosure rather than treatment, but it shows that defensive practice does occur when mental health workers are exposed to liability.

2. Defensive practice as a good thing

The issue of defensive practice, like all other policy concerns, must be weighed up against the benefits of imposing a duty of care.[254] In *Maulolo*, Wild J said that whether tortious duties will have a positive or a negative effect on doctors is a "fraught issue capable of almost endless debate".[255] Fanning argues that requiring doctors to comply with a standard of reasonable care according to the standards of their profession will lead to better treatment of patients.[256] He argues that the idea of

[248] Fanning, above n 246, at 95.
[249] *Maulolo*, above n 26, at 7; Van de Wetering, above n 16, at 17.
[250] See Richard Mullen, Anita Admiraal and Judy Trevena "Defensive practice in mental health" (2008) 121(1286) The New Zealand Medical Journal 85 at 87, where it was found that the practices most often perceived as defensive by New Zealand mental health professionals were asking patients questions about their safety, inpatient admissions and delayed discharges.
[251] Toni Wise "Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effect of Tarasoff" (1978) 31 Stanford Law Review 165 at 187.
[252] Mental Health Commission "Review of the Implementation of the Privacy Act 1993 and the Health Information Privacy Code 1994 by District Health Boards' Mental Health Services" (Mental Health Commission, Wellington, 2002) at 35.
[253] Mental Health Commission, above n 252, at 35.
[254] Booth and Squires, above n 93, at 181.
[255] *Maulolo*, above n 31, at [33].
[256] Fanning, above n 246, at 97.

defensive practice implies that doctors and patients have divergent interests – whilst patients want to get well, doctors primarily want to avoid litigation.[257] However, in reality, doctors and patients each want the patient to get well *and* to avoid litigation. There is therefore no need to employ defensive strategies.[258] Furthermore, a doctor who is worried about negligence liability may well be more thorough and attentive than a doctor who is not worried about such liability.[259] In the current context, defensive practice may therefore lead to greater attentiveness to the safety of potential victims.

However, defensive practice is not always beneficial. There will be occasions where a doctor's judgment of what is in the best interests of the patient conflicts with their desire to avoid liability for failing to protect potential victims. For example, it has been argued that inpatients who repeatedly attempt suicide may actually need a "limit setting" approach to their care, instead of more intensive treatment such as constant observation in order to reduce risk of liability.[260] By analogy, it may be that patients who become violent in inpatient settings would be better off being treated in the community. However, defensive practice by psychiatrists in response to a duty to protect could make this unlikely.

3. Defensive practice already pervasive

Psychiatrists in New Zealand already face several other forms of liability. These include Health and Disability Commissioner (HDC) cases, professional disciplinary proceedings, inquiries, and perhaps most worrisome of all for doctors, a "trial by media". Therefore, additional liability in negligence may not be especially significant – it may be that doctors in New Zealand already have an attitude of "cautious self-protection". Indeed, studies suggest that despite the no-fault ACC compensation

[257] Fanning, above n 246, at 97.
[258] Fanning, above n 246, at 97.
[259] Fanning, above n 246, at 97. See also Wayne Cunningham and Susan Dovey "Defensive changes in medical practice and the complaints process: a qualitative study of New Zealand doctors" (2006) 119(1244) The New Zealand Medical Journal 2283 at 2288 for examples of defensive practice in New Zealand resulting in some good outcomes.
[260] Mullen, Admiraal and Trevena, above n 250, at 86.

scheme in New Zealand, doctors still practise defensively in a similar way to doctors in countries where there is a risk of tortious legal action.[261]

4. Summary on defensive practice

Defensive practice is a real risk if a duty to protect is imposed upon psychiatrists in New Zealand. It may lead to reluctance to treat potentially violent patients in the community, even when that would be in their best interests, and over-cautiousness in issuing certificates under the MH(CA&T)A. However, imposing a duty to protect may also have the obvious benefit of making psychiatrists more protective of potential victims. Defensive practice is also already pervasive, meaning that it is unlikely to be a decisive factor against the imposition of a novel duty.

D. Insurance Implications

There is no doubt that DHBs will face increased costs in liability insurance if psychiatrists are exposed to negligence claims. One policy argument is that this will divert funds away from health services, and so a duty of care should not be imposed. However, few successful cases are likely to be brought against DHBs, due to the limited nature of the duty. The ACC statutory bar will also mean that successful negligence actions for damages will be rare, as gross negligence will have to be proven. It also appears that resource arguments have become less impressive to the courts in recent years, due to the lack of empirical evidence about funds being diverted from other services.[262] Thus this policy argument is not a strong factor against the imposition of a duty.

[261] Cunningham and Dovey, above n 259, at 2289; Mullen, Admiraal and Trevena, above n 250, at 90. Note that New Zealand psychiatrists can still be liable for exemplary damages, under the Accident Compensation Act 2001, s 319. See *Bottrill v A* [2003] 2 NZLR 721 (PC) at [37] per Lord Nicholl: exemplary damages require "truly exceptional and outrageous" conduct, as cited in *Couch*, above n 10, at [11].
[262] Booth and Squires, above n 93, at 177.

E. Summary on General Policy Arguments

It is a general principle of tort law that where there has been a wrong the law should provide a remedy.[263] This principle supports the imposition of a duty to protect. The hope is that a duty on psychiatrists would both decrease the incidence of tragic events like Mark Burton murdering his mother, and allow for adequate compensation for the victims where tragedies do occur.

There are difficulties with imposing a standard of care based on what the psychiatrist "should have known", or on what they did know, due to their inability to reliably predict violence. Nonetheless, psychiatrists are only likely to be held responsible if they fail to see that violence was imminent in short-term, high-risk situations. While breaching confidentiality may well damage the therapeutic relationship, there is already a consensus that this is permissible in exceptional situations. The practice of defensive medicine is not a strong policy argument against a duty of care, due to it already being pervasive. More expensive insurance is also not a strong policy factor, due to the lack of empirical evidence about diversion of funds. It is concluded that the policy matrix does not provide compelling reasons to deny a duty to protect, provided its parameters are properly drawn.

[263] *Couch*, above n 10, at [69]; Booth and Squires, above n 93, at 166.

Chapter 6: Conclusion

A. When Will a Duty to Protect Be Imposed?

The aim of this dissertation has been to discuss how a New Zealand court might decide: firstly, whether liability for failure to protect a potential victim of their patient would be imposed on a psychiatrist, and secondly, the scope of the duty should it be imposed. This began with an understanding of the approach generally taken to the issue of novel duties of care in New Zealand, the two broad inquiries of proximity and policy. The cases suggest that proximity will be found when there is either an individual or a sufficiently delineated class of people that the psychiatrist knows to be at a distinct or special risk of harm from their patient. A class will be sufficiently delineated when it would be practical for the psychiatrist to warn every member of that class. This requirement means that proximity will only be found in certain, narrow circumstances. The examples discussed generally involved the parameters of age, gender, physical characteristics and location. Thus a class of "young females living in apartments with balconies near intersection X" was found to be sufficiently delineated.[264] No specific threats need be made by the patient in order for the psychiatrist to owe a duty. Instead, a history of violence towards an individual or a sufficiently delineated class that meant the psychiatrist should have known that the potential victims were at risk will be enough for proximity to arise.

The finding that proximity will be narrowly confined has an important effect on the policy inquiry. Regarding policies embedded in the statutory background, it means that the considerable barrier of the duty conflicting with the MH(CA&T)A is largely negated. Over-detention would not be encouraged if a duty were only owed where the psychiatrist could actually have warned the potential victim. Moreover, the rest of the statutory background seems to offer some support for the imposition of a duty. While some statutes are neutral, several show the general policy of Parliament is to promote public safety over privacy concerns in certain circumstances. The issues of predicting violence, breaching confidentiality, defensive practice and insurance implications do not pose a decisive barrier to the imposition of a narrow duty of care. The alternative

[264] *Jane Doe*, above n 186, at [158], [183] and [185].

statutory remedies discussed, such as professional discipline and HDC complaints, will not adequately compensate injuries in cases of graphic violence. Therefore, the tort law goal of remedying wrongs favours such a duty.

I conclude that a duty to protect would be imposed upon psychiatrists in New Zealand in narrow circumstances. The statutory background slightly supports such a duty, and other policy concerns do not negate it. The duty would be narrowly confined on the basis of the strict requirement for proximity.

B. General Principles: Negligence Liability for the Actions of Third Parties

This dissertation has traversed the developing area of tort liability for the actions of third parties. The conclusion reached is in keeping with the general prohibition – only lifted in special circumstances – on imposing liability for failing to prevent harm caused by someone else. The basis for this principle is deep-seated – each individual is treated as a moral agent responsible for their own actions, and is not compellable to act for the benefit of others.

There are some exceptions to the rule, such as parents bearing responsibility for the actions of their children. If, exceptionally, a party is not treated as morally responsible for their harmful actions, some other party may be "deemed responsible", and may owe a duty of care to an injured party. Psychiatric patients will often be a paradigm example of people who are not morally responsible for their own actions. The law recognises this in requiring people to be fit to stand trial, and in absolving them of criminal blame if they are insane. Therefore, in some circumstances, psychiatrists may be the most appropriate parties to deem responsible for their patients' actions. Tools such as medication, therapy and compulsory detention give a psychiatrist power over their patient that is not a feature of other relations between adults in society. This special relationship, consisting of the crucial element of control or the ability to assert control, means that psychiatrists will be more able than others to take steps to protect potential victims. However, successful actions that meet all of the requirements discussed in this dissertation are likely to be rare, and therefore a case that results in formal judicial recognition of a duty to protect may not occur in New Zealand any time soon.

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