

# FEDERAL COURT OF AUSTRALIA

## Herron v HarperCollins Publishers Australia Pty Ltd (No 3) [2020] FCA 1687

File numbers: NSD 1620 of 2017  
NSD 1621 of 2017

Judgment of: **JAGOT J**

Date of judgment: 25 November 2020

Catchwords: **DEFAMATION** – alleged defamations arising from chapter in second respondent’s book published by first respondent – where imputations relate to applicants’ conduct in respect of the administration of deep sleep therapy at Chelmsford Private Hospital – where imputations based on findings of Royal Commission – whether defences of justification, qualified privilege, contextual truth and fair report/fair summary apply – defences applied to conveyed imputations – applications dismissed

Legislation: *Defamation Act 2005* (NSW) ss 8, 25, 26, 28, 28(1)(b), 28(4), 29, 29(1), 29(4), 30, 30(1)(a), 30(1)(b), 30(1)(c), 30(3), 30(3)(a), 30(3)(b), 30(3)(c), 30(3)(d), 30(3)(e), 30(3)(f), 30(3)(g), 30(3)(h), 30(3)(i), 30(3)(j), 30(4)  
*Evidence Act 1995* (Cth) s 135  
*Private Hospitals Act 1908* (NSW)  
*Registration of Births, Deaths and Marriages Act 1973* (NSW) s 57(4)

Cases cited: *Amalgamated Television Services Pty Ltd v Marsden* (1998) 43 NSWLR 158  
*Austin v Mirror Newspapers Ltd* (1985) 3 NSWLR 354  
*Australian Broadcasting Corporation v Chau Chak Wing* [2019] FCAFC 125; (2019) 271 FCR 632  
*Australian Broadcasting Corporation v McBride* [2001] NSWCA 322; (2001) 53 NSWLR 430  
*Boyd v Mirror Newspapers Ltd* [1980] 2 NSWLR 449  
*Burchett v Kane* [1980] 2 NSWLR 266  
*Chakravarti v Advertiser Newspapers Ltd* [1998] HCA 37; (1998) 193 CLR 519  
*Channel Seven Sydney Pty Ltd v Mahommed* [2010] NSWCA 335; (2010) 278 ALR 232

*Chau v Fairfax Media Publications Pty Ltd* [2019] FCA 185  
*Cook v Alexander* [1974] 1 QB 279  
*DIF III – Global Co-Investment Fund LP v Babcock & Brown International Pty Limited* [2019] NSWSC 527  
*Director of Public Prosecutions v Gill* [1993] NSWCA 84  
*Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553  
*Fairfax Digital Australia & New Zealand Pty Ltd v Kazal* [2018] NSWCA 77; (2018) 97 NSWLR 547  
*Fairfax Media Publications Pty Ltd v Chau* [2020] FCAFC 48  
*Fairfax Media Publications Pty Ltd v Kermode* [2011] NSWCA 174; (2011) 81 NSWLR 157  
*Farquhar v Bottom* [1980] 2 NSWLR 380  
*Favell v Queensland Newspapers Pty Ltd* [2005] HCA 52; (2005) 79 ALJR 1716  
*Feldman v Nationwide News Pty Ltd* [2020] NSWSC 26  
*Gill v Walton* (1991) 25 NSWLR 190  
*Goody v Odhams Press Ltd* [1967] 1 QB 333  
*Greek Herald Pty Ltd v Nikolopoulos* [2002] NSWCA 41; (2002) 54 NSWLR 165  
*Holt v TCN Channel Nine Pty Ltd* [2014] NSWCA 90; (2014) 86 NSWLR 96  
*Hart v Herron* (1984) Aust Torts Reports 80-201  
*Herron v McGregor* (1986) 6 NSWLR 246  
*Hockey v Fairfax Media Publications Pty Ltd* [2015] FCA 652; (2015) 237 FCR 33  
*Horrocks v Lowe* [1975] AC 135  
*John Fairfax Publications Pty Ltd v Zunter* [2006] NSWCA 227  
*Junius v Messenger Press* [1999] SASC 99  
*Lange v Australian Broadcasting Corporation* [1997] HCA 25; (1997) 189 CLR 520  
*Lewis v Daily Telegraph Ltd* [1964] AC 234 (HL)  
*Macquarie Radio Network Pty Ltd v Dent* [2007] NSWCA 261  
*McIntyre v R* [2009] NSWCCA 305; (2009) 198 A Crim R 549  
*Mirror Newspapers Ltd v Harrison* [1982] HCA 50; (1982) 149 CLR 293  
*Mirror Newspapers v World Hosts* [1979] HCA 3; (1979) 141 CLR 632  
*Morgan v John Fairfax & Sons Ltd (No 2)* (1991) 23 NSWLR 374

*Nationwide News Pty Ltd v Moodie* [2003] WASCA 273; (2003) 28 WAR 314  
*Nationwide News Pty Ltd v Rogers* [2002] NSWCA 71  
*Pamplin v Express Newspapers Ltd* [1988] 1 WLR 116 (CA)  
*R v Knight* (1988) 35 A Crim R 314  
*Radio 2UE Sydney Pty Ltd v Chesterton* [2009] HCA 16; (2009) 238 CLR 460  
*Readers Digest Services Pty Limited v Lamb* [1982] HCA 4; (1982) 150 CLR 500  
*Roberts v Bass* [2002] HCA 57; (2002) 212 CLR 1  
*Rogers v Nationwide News Pty Ltd* [2003] HCA 52; (2003) 216 CLR 327  
*Rush v Nationwide News Pty Ltd (No 7)* [2019] FCA 496  
*Sands v Channel Seven Adelaide Pty Ltd & Anor* [2010] SASC 202  
*Secretary, Department of Health and Community Services v JWB and SMB [Marion's Case]* [1992] HCA 15; (1992) 175 CLR 218  
*Singleton v John Fairfax & Sons Ltd (No 1)* [1983] 2 NSWLR 722  
*TCN Channel Nine Pty Ltd v Pahuja* [2019] NSWCA 166  
*Thom v Associated Newspapers Ltd* (1964) 64 SR (NSW) 376  
*Trkulja v Google LLC* [2018] HCA 25; (2018) 263 CLR 149  
*Waterhouse v Broadcasting Station 2GB Pty Ltd* (1985) 1 NSWLR 58

Division:	General Division
Registry:	New South Wales
National Practice Area:	Other Federal Jurisdiction
Number of paragraphs:	915
Dates of hearing:	1–5, 9–12, 15–19, 22–26, 29 and 30 June, 1–3, 6–8, 22 and 29 July, 3, 4, 6, 10, 12, 13, 26–28 August 2020
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Respondents:

## **ORDERS**

**NSD 1620 of 2017**

**BETWEEN:**            **JOHN HERRON**  
Applicant

**AND:**                **HARPERCOLLINS PUBLISHERS AUSTRALIA PTY LTD**  
**ACN 009 913 517**  
First Respondent

**STEVE CANNANE**  
Second Respondent

**ORDER MADE BY: JAGOT J**

**DATE OF ORDER: 25 NOVEMBER 2020**

### **THE COURT ORDERS THAT:**

1.        The originating application be dismissed.
2.        The applicant pay the respondents' costs as agreed or taxed.

Note: Entry of orders is dealt with in Rule 39.32 of the *Federal Court Rules 2011*.

## **ORDERS**

**NSD 1621 of 2017**

**BETWEEN:**            **JOHN GILL**  
Applicant

**AND:**                **HARPERCOLLINS PUBLISHERS AUSTRALIA PTY LTD**  
**ACN 009 913 517**  
First Respondent

**STEVE CANNANE**  
Second Respondent

**ORDER MADE BY: JAGOT J**

**DATE OF ORDER: 25 NOVEMBER 2020**

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## REASONS FOR JUDGMENT

**JAGOT J:**

### **1. INTRODUCTION**

- 1 These reasons for judgment concern the applicants' claims for defamation arising from a chapter in a book titled *Fair Game: The Incredible Untold Story of Scientology in Australia* (HarperCollins Publishers Australia Pty Limited, 2016) (the **Book**). The first respondent (**HarperCollins**) is the publisher and the second respondent (**Mr Cannane**) is the author of the Book. The background to Chapter 14 titled "Deep Sleep" (the **Chapter**) is the Royal Commission conducted by Acting Justice Slattery between 1987 and 1989 (**Royal Commission** into Deep Sleep Therapy) and the resulting multi-volume Royal Commission report. Mr Cannane's thesis, which the Chapter explores, is that the Royal Commission did not expose the role of the Church of Scientology in bringing to light the abuse of patients in the administration to them of so-called deep sleep therapy (**DST**) and electro-convulsive therapy (**ECT**) at Chelmsford Private Hospital (**Chelmsford**). The applicants are referred to in the Chapter as two of the four doctors involved in DST at Chelmsford.
- 2 As the respondents submitted, the reference to DST as involving "sleep" and "therapy", on the evidence in this case, is a misleading euphemism. The evidence is clear. The patients at Chelmsford subjected to DST were dosed with barbiturates to a level of deep unconsciousness, sufficient so that they had to be fed by a naso-gastric tube and were routinely incontinent. When they became rousable at the end of the period of a dose, they were dosed again to maintain them in a general state of unconsciousness for extended periods (such as for 10 days). The barbiturates used involved a small gap between sedating and fatal levels. There was no doctor routinely involved in the administration of the drugs to the patients or in their observation. Nurses were left with the responsibility to decide when and how much of the drugs to administer in a range specified on a pro-forma treatment sheet signed by one of the doctors involved in the use of DST – Dr Bailey, Dr (now Mr, given his deregistration as a medical practitioner for conduct unrelated to Chelmsford) Herron, and Dr Gill who was also a part owner of Chelmsford. While under DST the patients were given ECT. Oxygen, muscle relaxants and anaesthetic were not routinely given to patients being administered ECT despite these being standard requirements at the time.

- 3 As the respondents submitted, leaving aside the views of the applicants, the expert evidence in this proceeding is unanimous. DST was a dangerous experimental treatment with no medical justification by the 1960s and 1970s when it was being administered at Chelmsford. The way in which ECT was given at Chelmsford, without oxygen, muscle relaxants and anaesthetics, also did not meet the appropriate standards at the time. Further, it should be inferred from the evidence that none of the patients were informed about the dangers associated with DST and thus were not in a position to give informed consent to the treatment. A significant number of patients died while under or immediately after the administration of DST in circumstances where it should be inferred from the evidence that DST caused their deaths. Mr Herron and Dr Gill continued to administer DST despite knowing of the deaths and took none of the steps that would have been necessary at the time to investigate the cause of death and suspend or cease the treatment if the cause could not be mitigated. On the evidence in this case, the unavoidable conclusion is that the dangers of DST were so great the cause of death could not be mitigated if DST continued. The conclusion which must be drawn on the evidence is that DST should never have been performed at all at Chelmsford. To subject patients to it as occurred at Chelmsford in the 1960s and 1970s was unethical, grossly negligent and involved sustained medical malpractice by reference to the applicable standards at the time.
- 4 As the respondents submitted, due to the Royal Commission and its findings, these matters form a notorious part of the medical and social history of New South Wales. The applicants have sought to use the vehicle of this litigation, in effect, to prove that the Royal Commission did them a serious injustice by accepting a “Scientology version of events”. The reality is that the expert evidence called by the respondents and the otherwise admissible evidence from experts who were involved in the Royal Commission leaves room for only one credible version of events – that at the time it was administered it should have been obvious to those doctors with knowledge of its details (including the applicants) that DST was a dangerous experimental treatment for which there was no medical indication for any patient subjected to it at Chelmsford. However, the applicants’ evidence and submissions are fixated on a single objective – to have the findings in this proceeding rewrite history and vindicate their conduct despite the overwhelming evidence to the contrary and the lack of any cogent evidence to support them. As the respondents put it:

Instead of expert evidence, the Applicants wave vaguely in the direction of ‘literature’ which it is said may have supported the treatment being provided at Chelmsford. But that literature describes something very different to what occurred at Chelmsford.

...

There is not a skerrick of evidence to justify what was done at Chelmsford. It was a treatment that put patients at a significant risk of death, which risk came home on numerous occasions.

5 The applicants' submissions create their own difficulties. They contain material which appears to be of marginal relevance. They are, in large part, highly selective and tendentious. The view they present of the evidence is distorted, as if the evidence were being evaluated through the lens of the individual applicants and their unshakeable views that DST was an appropriate treatment and that the applicants were unfairly condemned by the public and the Royal Commission who were in turn hoodwinked into accepting a "Church of Scientology version of events". The deaths of patients under DST are presented as an acceptable consequence of some perverse risk-benefit analysis (in which the risk is not disclosed to the patient and the benefit merely assumed). Deaths under and as a result of DST (a supposed treatment) are compared to deaths of all psychiatric patients from all causes over time as if this could provide some justification for DST. Patients who survived and ultimately complained and sued are characterised as liars and troublemakers who should have been grateful for having received DST. The applicants' submissions consistently identify any discrepancy in a person's version of events over time as evidence that the person is a liar or fantasist, explain away evidence as a result of the adverse influence of publicity and the Chelmsford Victims Action Group, and otherwise mischaracterise any material that does not fit with the applicants' worldview of a false narrative (the so-called "Scientology version of events") unfairly perpetrated on them over decades. The fact that honest witnesses may give an honest core of evidence but nevertheless make mistakes about details (even numerous details), particularly involving traumatic events or events decades in the past, seems to have escaped the applicants. Mistakes about details are not a necessary indicator of unreliability, let alone conscious dishonesty. Nor is the fact that the witnesses were unwilling to give evidence at one time and later willing to give more details about their trauma or their experience over time a sign of lying. A person's perspective on what has happened to them may change over time with no dishonesty involved. I had the benefit of seeing the witnesses give evidence (excluding the evidence by way of hearsay notices). The applicants' repeated accusations of dishonesty against witnesses called by the respondents are simply unsustainable in the face of their evidence, viewed fairly and as a whole.

6 I have concluded that a number of the pleaded defamatory imputations are not conveyed by the matter complained of. To the extent that defamatory imputations are conveyed, I am also

satisfied that they are substantially true so the respondents have the benefit of the defence of justification in s 25 of the *Defamation Act 2005* (NSW) (the **Act**). The respondents are also entitled to the defence of qualified privilege for the publication of defamatory matter as provided for in s 30 of the Act. As a result, the proceedings must both be dismissed with costs.

## **2. THE BOOK**

7 HarperCollins published the Book in 2016. Over 8,500 copies were sold. Chapter 14 is headed “Deep Sleep”. It focuses on the role that the Church of Scientology played in exposing the abuses at Chelmsford and ensuring that the Royal Commission was held.

8 Part of the focus of the Chapter is on a patient, Barry Hart. Mr Hart went to see Mr Herron as he was suffering from anxiety brought on by what Mr Hart believed to be botched plastic surgery. As well as being a gym owner, he was a part-time model and an actor and believed his modelling and acting career were over. According to the Chapter, after arriving at Chelmsford he was asked to sign a form which he quickly scanned and noticed that it contained a disclaimer giving permission to perform electric shock treatment. Wanting nothing to do with shock treatment, Mr Hart refused to sign the form. When admitting that he was nervous, the Chapter states that Mr Hart was then given a pill to calm his nerves. The Chapter continues at p 177:

[f]or ten days Barry Hart was sedated with near-fatal doses of barbiturates, and while in a drug-induced coma, was given electric shock treatment on six occasions without his consent. His respiratory rate rose from 16 breaths per minute to 150. His temperature peaked at 39.9 [degrees Celsius]. He became incontinent, cyanosed and went into shock.

9 After “emerging from an enforced 10-day coma”, the Chapter states, Mr Hart called his parents who arranged for another doctor to visit Chelmsford and assess him. When out of hospital, Mr Hart realised his “brain was damaged, his anxiety was far worse, and he was suffering from post-traumatic stress”: p 179. The Chapter then states that two years after Mr Hart “nearly died at Chelmsford” his solicitor was able to access his medical records. The Chapter states at p 180:

...[w]hen they arrived, what was missing was just as critical as what was there: there was no signed consent form for shock treatment, and the bottom part of the admission slip had been cut off.

The files reinforced what Barry knew was the truth: he had not consented to being sedated and given shock treatment.

10 Mr Hart’s experience as detailed in the Chapter is one of a number of experiences of Chelmsford patients that are collectively described as “a catalogue of psychiatric abuse and malpractice”:p 184.

- 11 The person responsible for introducing DST to Chelmsford is identified, Dr Harry Bailey. It is said that Dr Bailey's experiments with DST at Chelmsford began in 1963. He used it for a wide variety of disorders claiming an 85% success rate with no credible evidence to back up this claim. He ignored the fact that other psychiatrists had rejected his theories and that a trial of DST at Parramatta had been discontinued as too dangerous. The treatment involved a mortality rate of 1% to 3% and had a well-documented set of potentially serious complications but Dr Bailey ignored the safeguards used by Dr Sargant, whose work had inspired Dr Bailey's experiments at Chelmsford. The Chapter records that these warnings did not deter Dr Bailey and his fellow Chelmsford doctors, John Herron, John Gill and Ian Gardiner. Nor did "the death toll mounting before their eyes": p 179. Details of some of the deaths at Chelmsford are then given.
- 12 The story then returns to Mr Hart and his attempts to obtain legal redress for what he was subjected to at Chelmsford.
- 13 The Chapter moves then to a consideration of the hitherto unknown role of Rosa Nicholson, a nurse, in exposing the events at Chelmsford in conjunction with the Church of Scientology.
- 14 Ultimately, as the Chapter contends, the role of Scientology in the "exposure of psychiatric abuses inside Chelmsford was arguably Scientology's finest moment in Australia": p 198. This culminated in the announcement by the NSW Government in 1988 that there would be a Royal Commission into DST. As the Chapter explains (p 192), the Royal Commission ran for close to two years. Nearly 300 witnesses gave evidence including patients, nurses, the surviving Chelmsford doctors (Dr Bailey having committed suicide in 1985), senior bureaucrats and former Ministers. The final Royal Commission report ran close to two million words. It revealed that 24 DST patients had died at Chelmsford between 1963 and 1979 with another 24 committing suicide within a year of release. It found that Dr Bailey had falsified as many as 17 death certificates and many patients received the treatment without their consent. The Department of Health was criticised for neglecting to carry out proper checks at Chelmsford and for failing to properly investigate the deaths.
- 15 The Chapter observes that while the Royal Commission report exposed the truth about DST at Chelmsford it did not get to the bottom of the role of the Church of Scientology and Ms Nicholson in that exposure: p 192. The balance of the Chapter focuses on the work of Ms Nicholson, in conjunction with the Church of Scientology, in exposing the practice of DST at

Chelmsford. The Chapter ends by observing that Ms Nicholson's achievements in exposing Chelmsford had been overlooked both during her life and at the time of her death in 2015.

### 3. THE IMPUTATIONS AND DEFENCES

16 The applicants allege that the Chapter conveys the following defamatory imputations:

	<b>Imputation</b>	<b>Statement of Claim paragraph</b>	<b>Accept carried or not</b>	<b>Pages of the Book</b>
A.	The applicant's gross negligence as a psychiatrist nearly killed his patient Barry Hart	Herron 4(a)	Yes T2765.19-21	5, 176, 177, 180, 185, 188
B.	The applicant, a psychiatrist, falsely imprisoned his patient Barry Hart	Herron 4(b)	Yes [27] R's Subs	176, 177, 188, 189
C.	The applicant, a psychiatrist, caused his patient Barry Hart to deteriorate, in ten days, from a fit 37-year old man in peak physical condition to a person in agony and distress, vomiting blood and unable to move his limbs	Herron 4(c)	Yes T2765.19-21	5, 176, 177, 178
D.	The applicant, a psychiatrist, caused his patient Barry Hart to be sedated and given electric shock treatment on six occasions without Mr Hart's consent	Herron 4(d)	Yes T2765.19-21	5, 177, 180, 188, 189, 194
E.	The applicant, a psychiatrist, used deep sleep treatment on his patients, despite trials by other doctors deeming the practice too dangerous*	Herron 4(e) Gill 4(a)	No [31] R's Subs	5, 178, 179, 190, 192, 194, 196, 198, 200
F.	The applicant, a psychiatrist, continued to use deep sleep treatment on his patients despite the number of deaths it caused*	Herron 4(f) Gill 4(b)	No [34] R's Subs [Subsequently changed to Yes]	5, 177, 178, 179, 180, 190, 194, 196, 198, 200, 201
G.	The applicant, a psychiatrist, falsified	Herron	No [36] R's	179, 190

	death certificates*	4(g) Gill 4(c)	Subs	
H.	The applicant, a psychiatrist, lied to his patients' families about how ill the patients were and denied those families visitation*	Herron 4(h) Gill 4(d)	No [38] R's Subs	179, 190, 192, 194, 196, 198, 200, 201
I.	The applicant's gross negligence as a psychiatrist caused his patient Barry Hart to suffer brain damage and post traumatic stress	Herron 4(i)	Yes T2765.19-21	5, 177, 179
J.	The applicant's gross negligence as a psychiatrist caused the death of many of his patients*	Herron 4(j) Gill 4(e)	No [41], [43] R's Subs	5, 177-181, 184, 190, 192, 194, 196, 198, 200, 201
K.	The applicant, a psychiatrist, engaged in sustained medical malpractice and abuse of his patients*	Herron 4(k) Gill 4(f)	No [47] R's Subs	5, 177-182, 184, 190, 192, 194, 196, 198, 200, 201
L.	The applicant, a psychiatrist, defrauded his patients' health funds*	Herron 4(l) Gill 4(g)	No [49] R's Subs	183, 184, 190, 192
M.	The applicant, a psychiatrist, traumatised many of his patients by giving them deep sleep therapy without their consent*	Herron 4(m) Gill 4(h)	No [51] R's Subs	5, 177, 184, 190, 192, 194, 196, 198, 200, 201
N.	The applicant, a psychiatrist, assaulted and battered his patient Barry Hart	Herron 4(n)	Yes T2765.19-21	175, 177, 189

17 As will be apparent, all imputations concern Mr Herron. Only imputations E, F, G, H, J, K, L, and M (shaded in the table above) concern Dr Gill.



18 The respondents accepted that imputations A, B, C, D, I and N are conveyed but contended that imputations E, F, G, H, J, K, L and M are not conveyed.

19 The respondents relied on the following defences:

- (a) **Truth:** Any imputations which are conveyed are substantially true (section 25 of ... the Act);
- (b) **Contextual Truth:** Further imputations are conveyed by the matter complained of which are substantially true, such that any imputations which the Applicants prove were carried did not further harm the reputation of the Applicants (section 26 of the Act);
- (c) **Fair Report:** The relevant portions of Chapter 14 amounted to a fair report of proceedings of public concern, being the Royal Commission into Deep Sleep Therapy presided over by the Honourable Mr Acting Justice J.P. Slattery A.O. (section 29 of the Act);
- (d) **Fair Summary:** The relevant portions of Chapter 14 amounted to a fair summary of a public document, being the Report of that Royal Commission (section 28 of the Act);
- (e) **Statutory Qualified Privilege:** Chapter 14 was published under circumstance of qualified privilege (section 30 of the Act).

20 The applicants stressed that as the imputations concern misconduct of the most serious kind they cannot be proved by inexact proofs, indefinite testimony or indirect inferences: s 140(2) *Evidence Act 1995* (Cth); *Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336 at 361. Clear, cogent and strict proof is required to prove the truth of the imputations: *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* [1992] HCA 66; (1992) 67 ALJR 170 at 172 per Mason CJ, Brennan, Deane and Gaudron JJ. This may be accepted. I have kept this principle in mind in assessing the evidence. However, the principle does not mean that the evidence on which the respondents relied was inherently suspect, nor that the evidence on which the applicants relied was inherently reliable.

#### 4. THE LAY WITNESSES

##### 4.1 The applicants

21 Although Dr Gill is and Mr Herron was a medical practitioner (as noted, he was deregistered in the late 1990s in relation to events unconnected with Chelmsford) the majority of their evidence concerned issues of fact rather than opinion and it is convenient to deal with their evidence immediately.

22 From the whole of the evidence I formed strong impressions of Dr Gill and Mr Herron. They plainly believed that they had been the victims of a serious injustice wrought upon them by the

Church of Scientology, their former patients, and the Royal Commission. They were unable to accept criticisms of their treatment of their patients and patients generally in Chelmsford who were administered DST and ECT. They appeared powerfully motivated by a need to see themselves vindicated from the serious adverse findings made by the Royal Commission against them. Their entire approach to their conduct was self-justificatory and self-exculpatory. Any person who maintained that DST was a dangerous experimental treatment without any medical justification which caused the deaths of some patients and did serious harm to other patients was seen to be peddling a “Scientology version of events” irrespective of the overwhelming evidence that DST was indeed a dangerous experimental treatment without any medical justification which caused the deaths of some patients and did serious harm to other patients. Their evidence was driven by their need for vindication. In my view, this need coloured the whole of their evidence and made it generally unreliable unless supported by other objective contemporaneous evidence.

- 23 The applicants’ approach to the evidence in submissions was also implausible. Any inconsistency in the applicants’ evidence is explained away as a benign product of their age or the passage of time. Any inconsistency in the evidence of any other lay witness, however, is seized upon as a lie, a recent invention or a false narrative. It may be accepted that the passage of time has affected the quality of the contemporaneous lay evidence. But that does not mean that the evidence is unreliable. In particular, the applicants repeatedly used inconsistency about details as a means to undermine the credit of witnesses. The approach in the applicants’ submissions to the evidence is unrealistic. The submissions fail to recognise the overwhelming interest of the applicants in vindicating themselves from what they perceive as serious past injustices. They fail to recognise the lack of interest of any of the other lay witnesses to do other than tell the truth as best as they are able to do given the passage of time. They fail to recognise that the fact of the passage of time may be accepted but that the general effect of evidence (even if in the wrong sequence or incorrect as to details) may nevertheless be accurate. They fail to recognise that the experience of trauma may cause some details to recede in the memory but the central traumatic experience to be clearly recollected and relived.

#### **4.1.1 Dr Gill**

- 24 Dr Gill’s unreliability as a witness is evident from the examples on which the respondents relied as follows, which I accept:

- (a) Dr Gill’s evidence was that he did not accept that his patients were given deep

sleep therapy and that he gave his patient John Adams ‘light’ sedation. That is contrary to what Dr Gill told the Royal Commission where he clearly stated his involvement in ‘Deep Sleep Therapy’ and set out his reasons: Ex. 12, tab 2, pg. 4. It is also contrary to the actual regime of drugs given to John Adams, which involved the maximum number of drugs with the minimum amount of time between doses: Gill XXN [cross-examination] at T269.6-10.

- (b) Dr Gill’s evidence about ‘light’ sedation was also flatly contradicted by nurses’ notes. For example, in respect of patient MA, Dr Gill insisted that she was given ‘light’ sedation: Gill XXN at T283.9-10. But the nurses’ notes record that ‘Deep Sedation commenced at 10:10am’: Ex. 12, tab 4, pg. 68. The Court should accept that if Dr Gill had instructed the nurses to carry out anything other than ‘deep’ sedation, it would have been recorded here. Dr Gill’s attempted reconciliation of the note with his own evidence was nonsensical.
- (c) Dr Gill denied that his initial treatment of John Adams used the same regime of drugs as Dr Bailey: Gill XXN at T215.14-16. It clearly did: the same pre-printed standard treatment sheet was used. He used the same treatment sheet for patient MA. What’s more, Dr Gill’s own evidence was that his use of sedation therapy was based on discussions with Dr Bailey: Gill 2 [90(a)] (CB2 AFF000B, pg. 15).
- (d) Dr Gill could not explain the stark contrast between his evidence to the inquest of John Adams that he was ‘absolutely satisfied’ with the level of nursing care and his evidence to the Royal Commission that the monitoring of patients in the DST ward was not good enough on that occasion. Had Dr Gill come clean and admitted that he was concealing the truth from the Coroner, one might have more reason to believe his current evidence. Dr Gill could not bring himself to make that obvious admission: Gill XXN at T292.19-293.8.
- (e) Dr Gill stated that in respect of pages 176-177 of the Book, he did not consider ‘any of these first two pages as being – being factual’: Gill XXN at T67.3-4. When given the chance to clarify that statement Dr Gill stated that he considered those pages to be ‘totally irreconcilable with the events reported in the hospital records’: Gill XXN at T67.12.13. Yet many of the matters set out in those pages are not controversial and are clearly recorded in the hospital documents.
- (f) Dr Gill’s evidence was that he could not provide any observations about the level of sedation used for Dr Bailey and Dr Herron’s patients: Gill XXN at T227.17-23. Yet he told the Royal Commission in 1989 that the means by which he learnt about DST was by “talking to the doctors involved and observing the way it was administered at CPH”: Ex. 12, Tab 2, pg. 24.
- (g) Dr Gill wrote and signed a letter which said ‘This is to put in writing our verbal discussions...’: Ex. 12, Tab 14. Dr Gill sought to suggest that this could have referred to a discussion with someone other than himself: Gill XXN at T313. That is a speculative reading of the plain meaning of the words of the letter that Dr Gill wrote. It is an example of Dr Gill seeking to avoid obvious conclusions which do not work in his favour.

(Footnotes omitted).

- (1) Dr Gill gave evidence that Ms Nicholson had never worked in the DST ward (“I am quite satisfied that Ms Nicholson did not work in the sedation ward. She was a trainee nurse and replaced an [assistant] trainee nurse outside the sedation ward” so anything she said must be the “Scientology version of events”): this was incorrect and Dr Gill sought to explain away his error when confronted by it by maintaining that Ms Nicholson did not work in the DST ward on 8 November 1972;
- (2) Dr Gill gave evidence that he had never been called to the hospital because of a health department inspection (“Never was I called when there was an inspection of the health department”): the evidence was to the contrary;
- (3) Dr Gill denied ordering that medical records be removed to the matron’s flat but then admitted he merely had no recollection of doing so;
- (4) Dr Gill said he believed he had never used Dr Bailey’s pro-forma treatment sheet: but when the evidence proved to the contrary his position had to change;
- (5) Dr Gill said that he did not think he had one more DST patient after the death of John Adams: but the evidence shows that he administered DST to Barry Green the following month; and
- (6) Dr Gill said his understanding was that DST as administered at Chelmsford was still being conducted in other parts of the world: when there is no evidence to support this assertion and the weight of the evidence is overwhelming to indicate to the contrary that even when being administered at Chelmsford DST was an experimental treatment not being conducted in the same form anywhere else.

26 As the respondents also submitted, Dr Gill’s evidence must be assessed in light of his previous conduct to thwart attempts to scrutinise the conduct at Chelmsford. He moved Chelmsford documents to a squash court near Newcastle in which one of his companies had an interest so as to avoid them being obtained via a search warrant: T151.27-32. He recorded a conversation between Mr Herron and Marcia Fawdry without her knowledge or consent: T85.4-5.

27 The applicants’ submissions about Dr Gill’s evidence fail to recognise his overwhelming self-interest in having the Court accept a version of events which suits Dr Gill’s perceptions of having suffered a serious injustice at the hands of the Royal Commission.

#### **4.1.2 Mr Herron**

28 I accept the respondents’ submission that it is apparent that:

Mr Herron's approach to these proceedings was also to seek to defend DST as practised at Chelmsford at all costs and without regard to documents, previous evidence or objective likelihoods.

29 As the respondents said, the unreality of Mr Herron's evidence is apparent in his insistence that Audrey Francis demanded to be treated with DST having "read all the literature regarding sedation therapy" and that she "did not care" about the particular risks to her from DST arising from her conditions and weight: affidavit of John Herron dated 31 January 2020 (**Herron 2**) [104], (Court Book (**CB**) 2 AFF000F, p 21. However, as the respondents observed:

Mr Herron gave evidence about this consultation at an inquest into Ms Francis' death. Before the Coroner, Mr Herron regarded it as appropriate to provide a history of Ms Francis' problems and provide the Coroner with as much information as he could on the subject. Yet nowhere in Mr Herron's evidence before the Coroner is there any reference to Ms Francis insisting on having deep sleep treatment, knowing of the drugs that were proposed to be administered to her or having said that she had done research or read literature about sleep therapy: Herron XXN at T374.5-15. Rather, Mr Herron's evidence before the inquest was the following:

Q. Do you consider it is normally entirely safe to put a woman of her age, 66, to sleep for a lengthy period?

A. This is a judgement that has to be taken. She was in a very acute state of agitation. She was at least on the information doing things which put her at great risk and in confusion. One can do many things. She did have a history that recently during episodes of confusion, falling, hurting herself to the degree that it should be suspected that she could have a subdural haematoma. The reasons then of the treatment program and my considered opinion at the time was, this was the best treatment available to her at that time and what risk there was should be taken.

(Footnotes omitted).

30 Had Ms Francis insisted on DST irrespective of the risks (an inherently unlikely scenario), then Mr Herron would have informed the coroner to that effect. Yet he made it clear to the coroner that it was his recommendation (not Ms Francis's insistence) that she be subjected to DST. It is also apparent that Mr Herron alone judged that the risks should be taken. There is no suggestion in his evidence to the coroner that he provided sufficient information to Ms Francis so that she might understand the serious risks involved in DST for any person, let alone a person of her age and in her condition. Further, the respondents noted that Mr Herron's record of the consultation (MED00093.4 (Respondents' Tender Bundle (**RTB**) 7)) said:

Chronic drug and alcohol abuse with superimposed mood disorder. At first treat with Hemineurin, I will be happy to follow her up at Chelmsford and arrange with relatives future care.

31 As the respondents put it:

That is far removed from the conversation described by Mr Herron. Mr Herron sought to explain this by saying that the Ryde consultation document ‘fulfils the request’ and Mr Herron did not ‘believe it was necessary’ to record the details of what Ms Francis told him about her research in that report: Herron XXN at T371.5-39. In circumstances where the consultation was (as Mr Herron accepted) ‘very much out of the ordinary’, Mr Herron’s lack of credible explanation for the conversation not appearing in those notes tells strongly against the idea that any such conversation happened.

(Footnotes omitted).

- 32 As the respondents also pointed out, Mr Herron’s evidence about ECT at Chelmsford was not supported by the evidence. He said that patients were not given a morning dose of sedation if they were to be given ECT but the records show numerous cases of such sedation being given before ECT. His evidence about lightening before ECT is also irreconcilable with his evidence that the reason he did not give anaesthetic to patients who were being given ECT was that it would be dangerous to do so given their level of sedation. The fact is sedation patients were not generally given anaesthetic before ECT at Chelmsford presumably because the view was taken that their level of sedation was equivalent to being anaesthetised (which the expert medical evidence in this case indicates is a reasonable description of the level of sedation likely to be achieved in DST). This, however, led to highly distressing experiences for some patients (who were not sufficiently sedated to be unaware of ECT being performed on them). The fact that Mr Herron performed ECT on sedated patients without the routine use of anaesthetic, muscle relaxants and oxygen, when these were standard requirements, immediately calls into serious question his medical and ethical judgment.
- 33 Mr Herron accepted during the Royal Commission that 26 people had died during or immediately after DST and that DST was a significant contributing factor to their deaths but, in this proceeding, said he had changed his mind and did not accept that DST was a cause of these patients’ deaths. It is difficult to imagine Mr Herron having made any concession at any time unless it was unavoidable on the evidence. No cogent reason for the change in position was apparent other than Mr Herron’s self-interest in this proceeding.
- 34 Mr Herron’s evidence over time about what happened to Mr Hart’s admission form was inconsistent and unbelievable. The admission form had a space for a consent to ECT. The bottom of the form was cut off and replaced by a photocopy of an X-ray form. In *Hart v Herron* (1984) Aust Torts Reports 80-201 (*Hart v Herron*) Mr Herron gave this evidence:

When did you first notice that the bottom had been cut off?

I first found out the bottom, I first noticed, I first saw that the bottom had been cut off when I saw these documents in my barristers [sic] rooms within a few days of the trial

starting.

35 In the Royal Commission Mr Herron initially gave this evidence:

Q. When did you first become aware that Exhibit 196 [the Hart consent form] had been tampered with, on the bottom of the identification page?

A. It was in a conference with my solicitors, as I remember it, prior to *Hart v. Herron*.

36 This exchange later occurred in the Royal Commission:

Q. Yes. In those circumstances, have you ever made any enquiries about how this happened?

A. No, I haven't.

Q. Have you any knowledge at all about how it happened?

A. Yes

Q. What is that knowledge?

A. After it had happened and I can't really tell you the group of people, that someone as I remember it in the corridor of the hospital or a group of them said that they had solved all of my problems for me and they had cut off this bit of the document. I don't know who it was that actually cut the piece off and my response at that stage was almost identical to the response in the discussion with the lawyers.

37 When it was pointed out to him that this was inconsistent with his evidence in *Hart v Herron* his explanation was that he had been asked the wrong question in that proceeding. This exchange occurred:

Q. Let me take you to another question and answer. The question was, and I will show you the whole passage in a moment so you can look at the context:

'Q. You did not become conscious of it until your barrister drew your attention to it?

A. That is correct.'

Q. I would suggest to you that that was not an answer where you could say the wrong question was asked, that that's an answer which was untrue. You will find it about two thirds of the way down the page?

A. I still believe that my comments in relation to the 'When did you first notice that the bottom had been cut off' and I believe that the interpretation that I made to the word 'conscious' was physical knowledge and that's what I have answered the question to."

38 The answer of Mr Herron is evasive and self-serving.

39 I accept also the respondents' submission that the most significant reason for the Court to attribute little or no weight to Mr Herron's evidence about controversial matters is his approach to the manifest dangers of DST. This exchange occurred in the evidence:

No. Well, certain it is that you kept on administering DST until 1979, didn't you?---I did.

Yes. And that was in the face of, can I suggest to you, evidence – or overwhelming evidence about the serious dangers of DST?---The overwhelming evidence, if it could be called that – and I disagree with it being called that – was predominately due to the propaganda spread by the scientologists. There was – there is no real scientific basis to it. It had been practised in many countries and was still being practised in many countries.

40 This evidence is far from reality. The evidence about the dangers of DST is overwhelming and that fact ought to have been recognised as such by any reasonable medical practitioner with detailed knowledge of the treatment in the 1960s and 1970s. Mr Herron's continued insistence to the contrary merely confirms his determination to be vindicated at any cost for what he perceives as the injustices wrought upon him by the Church of Scientology, his patients, and the Royal Commission.

41 It may be accepted that Mr Herron is now 87 and his evidence was adversely affected by a deterioration in his condition in the midst of his cross-examination (resulting in his hospitalisation). As will be apparent below, I have taken into account the impact on Mr Herron's evidence caused by his hospitalisation. But nothing about these matters removes the fundamental issue about his evidence that it was manifestly directed to one end – vindication of his version of events about DST which had been rejected by the Royal Commission.

42 Contrary to the submissions of the applicants, I do not see any support for the applicants' positions in *Director of Public Prosecutions v Gill* [1993] NSWCA 84 and *Herron v McGregor* (1986) 6 NSWLR 246. It is one thing to succeed in the stay of criminal and disciplinary proceedings because of the passage of time and the effect that could have on the capacity to defend oneself. It is another to bring a proceeding alleging defamations relating to conduct from the 1960s and 1970s and to expect to benefit from favourable inferences given the exigencies of the circumstances.

## **4.2 Chelmsford nurses**

43 While the nurses were capable of giving expert opinions about nursing care, for the reasons given below, I do not accept that they were qualified to understand the particular risks associated with DST (although some plainly had serious concerns and went so far as to challenge the doctors about their practice, without result). As such, their opinions about the adequacy or appropriateness of the medical care given to DST patients at Chelmsford (as opposed to the quality of the nursing care) cannot be relied upon. The nurses were not medically



qualified and were not in a position to assess the propriety (or otherwise) of their involvement in DST. They were not able to assess the effect of the drugs on the patients other than by the crude method of observation. Contrary to the applicants' thesis, the nurses' experience in the DST ward did not make them capable of safely performing experiments in the titration of drugs on the patients. The fact is, unbeknownst to the nurses, they were in fact experimenting on the patients, albeit without the qualifications in anaesthesia which on the evidence would have been necessary to attempt to perform this role and without a detailed understanding of the fine line between sedation and death which the barbiturates used in DST involved. Accordingly, the applicants' attempts to rely on the nurses' evidence when it suited them concerning the quality of nursing care at Chelmsford cannot be accepted. The nurses were being asked to perform an impossible task – to try to safely administer a highly dangerous regime which a qualified anaesthetist in an intensive care unit would have had difficulty in managing. The fact that the nurses mostly did not recognise this at the time (although some certainly did) involves no criticism of them. They could not be expected to know what the doctors knew or should have known – that DST was an experimental and dangerous treatment for which there was no medical justification by the 1960s and 1970s. No amount of nursing care at Chelmsford could make the procedure safe and justifiable. The evidence of the nurses must be understood in this context.

#### **4.2.1 Jan Reid**

- 44 Mrs Reid started working at Chelmsford as a nursing assistant in 1972. In the early 1960s she had done nursing training but had not sat her final exams. Her standard shifts were Thursday, Saturday and Sunday evenings from 9pm until 7am but from 1974 she only worked Thursday and Sunday nights.
- 45 She recalled the DST ward as having six beds. There were generally one registered nurse and two unregistered nurses (either nurse's assistants or nurse's aides) on duty. There was never a resident doctor on premises at Chelmsford. The registered nurse on duty was in charge of the hospital during the shifts.
- 46 She recalled that DST patients were generally naked, in beds, each with a Ryles tube inserted into one of their nostrils. Every four hours Mrs Reid and the other nurses would undertake a routine which was standard for all DST patients. This included cleaning the patients' mouths, washing them and changing their sheets if they were incontinent, feeding them a mixture of

Sustagen and eggs through the Ryles tube, and checking, and recording on an observation chart, each patient's temperature, pulse, respiration and blood pressure.

47 When Mrs Reid was not involved in this routine she would sit in the door of the sedation ward and the nurses would take it in turns to walk and look around the other wards. Approximately every half an hour either Mrs Reid or the other unregistered nurse would walk through the sedation ward and look at each of the patients. Mrs Reid said that there was always at least one nurse sitting in the door of the sedation ward. If any patients were restless one of the nurses would go and check on them. As the patients were not catheterised if the nurses saw that a patient's sheets were wet they would change them immediately. During this routine Mrs Reid recalls that the DST patients were also generally administered capsules of Tuinal (a barbiturate) through the Ryles tube by either herself or another unregistered nurse. Mrs Reid remembers that it was usually 400mg, being two tablets, of Tuinal. On occasions Mrs Reid does remember the registered nurse on duty deciding that only 200mg of Tuinal should be administered. Mrs Reid stated that patients in the sedation ward did not generally wake during DST and appeared to her to be in a coma because they would not respond to anything happening around them including the nurse talking and lights turning on and off. Dr Bailey had said that if the patients opened their bowels they were not sedated deeply enough. Generally, patients under DST did not open their bowels and they were given an enema when they were lightened out of sedation at the end of DST. To the best of her recollection Mrs Reid believes that DST patients were usually sedated for approximately 21 days. Mrs Reid does not recall seeing standard treatment sheets setting out a drug regime. Mrs Reid recalls that the sedation ward and Chelmsford generally had very little emergency equipment.

48 Mrs Reid remembers patients receiving DST developing complications from their treatment including elevated temperatures, seeing blood in urine, and patients displaying distended abdomens. Mrs Reid also remembers seeing Mr Herron administer ECT to the patients in the sedation wards. Mrs Reid never observed Mr Herron administer either a muscle relaxant or an anaesthetic to a patient prior to administering ECT. Mrs Reid would assist Mr Herron whilst he gave ECT to ensure the patient's limbs did not bang against any hard surfaces and that the patient's jaw was kept up so that the airway was clear. Mrs Reid recalls one occasion whilst assisting Mr Herron that a patient became cyanosed after receiving ECT and appeared to be suffering from respiratory or cardiac arrest. Mrs Reid said that Mr Herron resuscitated the patient and continued the DST treatment.

- 49 To Mrs Reid, DST seemed at the time to be a very bizarre treatment. She was shocked at the large amounts of drugs that were administered to DST patients and at the fact that the drugs were administered by a nurse without the supervision of a doctor. Mrs Reid assumed at the time that DST was a normal psychiatric practice and believed that her concerns were just naivety. Mrs Reid particularly recalls the admission of one lady in the middle of the night where the patient had to be escorted kicking, screaming and scratching from her car to the sedation ward. Mrs Reid remembers that this patient took her glasses off her face and threw them into a bush at the front of the hospital. Mrs Reid could not recall the patient's name or the precise date. Mrs Reid also remembered one patient dying in the sedation ward whilst she was working. On this particular occasion Mrs Reid was working with Sister Stewart. Sister Stewart and Mrs Reid were preparing to commence the 6am routine when Sister Stewart came across a female patient not breathing in her bed. Sister Stewart told the other unregistered nurse to go and get Matron Robson who at the time lived in a cottage attached to the hospital. Mrs Reid does not recall a doctor attending to see the patient after the death. To the best of her recollection, the routine that the nurses undertook did not change in any way following the death. From her discussion with other staff at Chelmsford, Mrs Reid was aware of four other patients that had died in the sedation ward whilst she was employed at Chelmsford.
- 50 Mrs Reid recalled an incident when a patient escaped from the sedation ward. Mrs Reid stated that she was told by another nurse that there was a patient missing and that the police had brought the patient back to the hospital after finding him naked on Pennant Hills Road with a Ryles tubes hanging out of his nose.
- 51 Following her time at Chelmsford, Mrs Reid worked at Mount Carmel Hospital in the operating theatre for eight years. She then worked in pathology for approximately 25 years as a nursing and public relations manager. In hindsight and considering her training and experience since Chelmsford, Mrs Reid considers DST as practised at Chelmsford was unreasonably dangerous. In Mrs Reid's view the patients should have been nursed in intensive care unit type conditions with one nurse per patient, doctors on site, and full resuscitative equipment available.
- 52 In her oral evidence Mrs Reid said observations were done every four hours, not every half hour. Incontinent patients were changed during the four hourly routine observations. As she put it:

If there was no need to check them for – in between the four hours, they weren't checked. We just looked – just give them their treatments, their cleaning, their pulse, and doing their blood pressures, and doing their Sustagens, and turning them over. And

more often than not, that was when we changed, and if they were wet – if they weren't wet, we didn't change them.

53 Patients were occasionally restless nearing the end of their four hour sedation period but she never heard any of them talk. If they were being lightened out of sedation to go to the general ward at the end of their treatment they would be more restless. She said that under DST the patients were basically in a coma.

54 She gave this evidence:

The consent forms should have been in the normal papers that we had access to, the TPR charts and all the nurses writing, etcetera etcetera. It all should have been in one place.

And you don't remember seeing that, is that right? ---No.

55 She said she did not recall lesser doses of Tuinal being given and believed patients were routinely given the maximum dose of 400mg (two tablets) every four hours. She recalled Dr Bailey not allowing the dose to be decreased even if the Sister wanted to. She described Dr Bailey as "a terrible terrible person and [he] did some terrible things to people". She said:

Well, all I know, I will tell you this. Hornsby Hospital hated our guts because we were always relaying patients up to there with pneumonia and God knows whatnot, because they weren't looked after adequately, as far as their breathing was concerned.

56 She said that if patients were given lesser doses of Tuinal it would have occurred rarely. Urine output could not be measured other than by the number of times the patient had wet themselves. It was very rare for a patient to open their bowels under sedation. It was absurd to suggest patients were left in their own faeces while under sedation as it was rare for the patients to open their bowels. She thought the equipment available was inadequate but had never needed to resuscitate a patient. She said:

We didn't have any drugs it might have been pertinent to the situation. They were out in the drug cupboard out in another room, as in drugs that they used to – resuscitation, to re-start the heart, we didn't have any of those at hand. We had a sucker and an oxygen cylinder. That was it.

57 She said it was the general consensus of the staff that patients were not examined adequately before they were admitted and given the deep sedation.

58 I do not accept the applicants' submissions that as an untrained nurse Mrs Reid's observations are irrelevant. I accept her to be a witness of truth who gave generally accurate evidence of her recollections and views from the time she worked at Chelmsford. I accept her evidence that

early on in her time at Chelmsford she assumed DST was a healing treatment but also accept her evidence that she changed her mind while working there and before the Royal Commission.

#### **4.2.2 Julie Bothman**

59 Ms Bothman was employed as the matron at Chelmsford from about 10 August 1976 to 13 January 1977. Ms Bothman qualified as a general nurse at Bathurst Hospital in 1966, obtained an obstetrics certificate in about 1968 and a psychiatric nursing certificate in about 1970, and prior to her employment at Chelmsford worked in private hospitals for about five years, then as a nursing educator in 1975. After Chelmsford, Ms Bothman continued to work as a nurse educator between 1977 and 1991, and then in palliative care community services, until her retirement in 2013.

60 At Chelmsford Ms Bothman worked Monday to Friday between about 8am and 5:30pm, and was also on call for emergencies outside usual work hours. She said that at that time there were about 40 beds in the hospital, about 30 of which were allocated for non-sedation patients. Ms Bothman's duties covered the nursing operations of the entire hospital, including co-ordinating nursing and support personnel, co-ordinating chemist orders and supplies, providing general nursing to non-sedation patients and assisting doctors to administer ECT, and discussing patient care with families. Ms Bothman said that prior to commencing her employment at Chelmsford she was not given any training by a doctor in how DST was to be administered and was not aware of any training program for nurses prior to commencing work in the DST ward.

61 Ms Bothman's evidence was that during the morning shift, herself, one registered nurse and one nurses' assistant were in the DST ward; during the evening shift, one or two registered nurses and one or two nurses' assistants were in the whole hospital; and during the night shift, one registered nurse and one nurses' assistant were in the whole hospital.

62 She said that the registered nurses at Chelmsford either had a general (physical care) nursing certificate or a psychiatric nursing certificate, but not many had both, and that she considered that given the condition of the patients in the DST ward all nurses providing them care should have held a general nursing certificate.

63 Ms Bothman's evidence was that every four hours staff in the DST wards attended the patients' eye and mouth hygiene and skin care, repositioned patients from side to side, and checked patients' temperature, pulse and respiratory rate and recorded their findings. She said that patients were usually fed Sustagen or orange juice at the same time as medication was given

through the Ryles tube. Ms Bothman said that records for each DST patient included the “Day Book” which recorded any issues noted by the registered nurse on each shift, observation charts, medication charts, and daily fluid balance charts (which, I note, recorded the number of times the patient passed urine and not the amount of urine passed as this could not be measured given the patients were not catheterised and were wetting the bed). The nurses’ notes recorded contemporaneous observations made by the nurses, instructions given by a doctor, and any treatment administered by the nurse or a doctor. Ms Bothman also recalled an exercise book where the names of patients having ECT were recorded.

64 She said that during her time at Chelmsford, “there was never a doctor regularly on duty and there was not always a doctor present at the hospital.” During the first few months of her employment she recalled Dr Bailey visiting about once a week, and later not at all. Mr Herron routinely visited Chelmsford three times a week and on those occasions he administered ECT to DST patients, and that when a nurse had a concern with a patient he gave directions for care over the phone then made a follow-up visit shortly afterwards. Dr Gill visited Chelmsford several times a week for short periods and cared for other doctors’ patients, although by the end of her time at Chelmsford had care of several of his own geriatric patients.

65 Dr Gill’s actions organising admissions, dealing with staff and pay, reporting to the health department, and organising equipment and maintenance, gave Ms Bothman the impression that he was responsible for the running of the hospital.

66 She said that DST involved the following steps with respect to a patient:

- a) be admitted to the General Wards where they were given an initial administration of barbiturates by a registered nurse, which was usually an injection of Sodium Amytal;
- b) once unconscious, be moved to the Sedation Wards;
- c) have a Ryles tube inserted by a nurse through the nose to the patient’s stomach;
- d) be kept sedated for approximately 10 to 14 days in the Sedation Wards due to the registered nurse on duty administering to the patient a combination of drugs ... including Tuinal tablets every 4 to 6 hours, Neulactil tablets twice a day, and Serenace tablets twice a day, as well as Cogentin injections, Sodium Amytal injections, Atropine and Placidyl tablets when required. The registered nurse dispensed the medications, which were mixed with water and given either by the registered nurse or nursing assistant under direction via the Ryles tube;
- e) while sedated, be given ECT by either Dr Herron or Dr Gardiner ... usually ... every day except Sunday;
- f) be lightened from sedation by the administration of:

- i. Hylodorm Sustrels;
  - ii. Neulactil;
  - iii. Tuinal; and
  - iv. Magadan.
- g) while still unconscious, be bathed and dressed by a nurse before being transferred to the General Wards; and
  - h) recover from Sedation Treatment in the General Wards.

67 She said that “before and since I worked at Chelmsford, I have never seen barbiturates prescribed in such large quantities, or in the same combinations” and that she was instructed by Dr Bailey and nursing staff at Chelmsford to sedate DST patients to “a deep level of unconsciousness where they only responded to pain.” She recollected Dr Bailey and Mr Herron treating patients for “diagnoses including depression, personality disorders, schizophrenia and drug addiction, alcoholism and anxiety states”, that “regularly patients were admitted ...[and] Sedation Treatment commenced without the treating doctor being present at the hospital,” and further that she could not “recall any occasion when I observed Dr Bailey physically examine a patient at Chelmsford before the commencement of Sedation Treatment ... [and was] also aware that Dr Herron’s patients were not always physically examined at Chelmsford prior to the commencement of Sedation”, which caused her concern.

68 She said that due to their tolerance for barbiturates, drug addicts required “higher doses of the drugs ... than patients without a history of drug issues to reach the level of sedation expected by Dr Bailey and Dr Herron” and that this caused her concern, as the “higher doses of barbiturates ... put more stress on their respiratory system and meant that the line between deep sedation for a drug addict and death became relatively close”.

69 She said she recalls “seeing the occasional Sedation Treatment patient with restraints on their wrists” but could not recall seeing any patients with restraints on their ankles. She was told by “nurses in the Sedation Wards that restraints were used when Sedation Treatment patients became restless and thrashed around in bed to prevent injury or pulling out intragastric Ryles tube.”

70 She said that the sedation medications were given in accordance with a standard medication sheet, which were pre-signed by Dr Bailey and Mr Herron in bulk and entered into a patient’s file by nursing staff upon admission. She accepted that she had not given this evidence to the

Royal Commission and had said only that she could not recall Mr Herron having patients undergoing sedation. She explained that:

Dr Herron's use of sedation, when I first started, I don't remember him having any patients in sedation. But after the Audrey Francis hearing, there were patients of Dr Herron's came in after the hearing, and the reality was the treatment charts were signed by either Dr Bailey or Herron. But if there wasn't one there that had Dr Bailey's signature on it, then the nurses would use one that was signed by Dr Herron. So it was just a supply of treatment sheets in the drawer, and you just picked up the top one, and then put the patient's name in it. So the signature was the – of either of them, could be on that sheet, and it would be activated for that patient that was coming in.

71 She said that she did not recall “any consideration by either a doctor or a nurse of an individual patient's age, physical or emotional condition, medical history or size” prior to the determination of their sedation regime. Ms Bothman gave evidence that she was concerned by this due to the depressive effects on brain, heart and respiratory function caused by the barbiturates used, the fact that they were addictive, and that they had different effects on patients depending on their physiology. She agreed that nurses took a history from the patient on admission and administered tests and made observations. She thought the nurses did a pretty good job with respect to admissions.

72 She said that the matron and nursing staff were expected to exercise a large amount of discretion in relation to the sedatives administered, as the medication sheet set a wide range of dosages for many of the drugs. Tuinal, the main barbiturate medication, was to be administered four to six hourly. A number of medications were to be given “as required”. There was not always a doctor present who was familiar with DST and its administration. Dr Bailey gave nursing staff instructions to sedate patients to a level of unconsciousness so that the only thing they could feel was pain. She said she:

...observed that nursing assistants were expected to assess the medical condition of Sedation Treatment patients and make decisions about whether or not a registered nurse or doctor should be contacted ... Based on my experience ... I formed the view that this amount of responsibility was far above a nursing assistant's level of training regardless of how long they had been working in the Sedation Wards. I was particularly concerned about the nursing assistants on the evening and night shifts when there was less supervision and help available.

73 She agreed that some of the nurses erred on the side of caution within the confines of the proforma treatment sheet and prioritised the safety of the patient. She said one nurse in charge of the sedation ward, however, always complied with Dr Bailey's instructions about the required deep level of unconsciousness of the patient.



74 She said that she was given “strict orders that patients were not allowed to have visitors while they were in the Sedation Wards. I cannot remember who gave those instructions, but they applied to all patients regardless of the treating doctor.” She said:

I had never seen patients being sedated to that level, that they weren’t allowed to have visitors, and so that to me was not normal, no. And – and some of the – some of the families got quite upset about that, not being able to see their – the patient during that period of time, because if it was days, that’s a long time to have someone in hospital and not be allowed to visit.

...

And I want to suggest to you that you were not told that there was some rule or edict about visitors in the sedation ward?---No, I refute that. I definitely was told.

75 Her concerns about DST included the following:

- (1) “that it was safer to feed patients through an IV rather than through a Ryles tube to reduce the risk of choking ... [and] meant that the amount of fluids that a patient received could be accurately monitored”;
- (2) “I remember observing Sedation Treatment patients with urine or faeces in their beds. When patients were incontinent nurses changed their linen. As the patients were not catheterised there was no way for nursing staff to measure the exact amount of fluid discharged by a patient ... [which] was important to know ... [as] a method of monitoring a patient’s renal function”;
- (3) “it was inadequate record keeping to only keep four hourly charts, even when correctly filled in, because a patients’ condition could change so much within a four-hour period”;
- (4) on many occasions Dr Bailey promised he would visit Chelmsford to examine a patient about whom Ms Bothman had a concern, but did not; and on several occasions Dr Gill attended Chelmsford to examine a patient but “took little notice of what I had to say about the patient’s condition”, so that Ms Bothman began to call another private doctor to attend, but “there was at least one occasion that I recall needing a doctor urgently and [that doctor] was not available to attend ... because he had his own private patients to see”;
- (5) the risk of infection due to the use of one suction machine on all DST patients. The suction machine was used frequently to remove fluid build-up in sedated patients’ lungs, but in the event of a patient experiencing risk of respiratory distress, was also required to be used immediately on that patient without time for it to be properly

sterilised. Ms Bothman said that on one occasion, her observation of the pathology results of a number of patients with chest infections led her to believe that the suction machine had transferred staph aureus bacteria between patients and had infected the ward, and subsequent testing of the ward showed significant rates of staph aureus bacteria, particularly in the sucker machine. After these events Ms Bothman told Dr Gill she considered more suction machines should be purchased, but she is not aware of this ever occurring;

- (6) the emergency resuscitation equipment, which when she started her employment at Chelmsford was located on a tray outside DST ward in the clinic room, around the corridor and required a key to access (Ms Bothman organised to have this moved into the DST ward), and the drugs available to be administered in the event of a cardiac arrest which were out of date (which she organised to be replaced); and
- (7) there was no x-ray machine or blood/gas analysis machine at Chelmsford, which concerned her as “a doctor or nurse can only determine so much about [the patients’] condition through observing their symptoms and will often require further investigations ... in order to make a diagnosis. The speed with which a diagnosis is made is very important ... patients had to be transferred to a public hospital for scans or other investigations, thereby delaying treatment of any complications.”

76 Ms Bothman raised concerns about DST with Dr Bailey who said that:

Sedation Treatment is used overseas. It has an 85% success rate. Dr William Sargent uses Sedation Treatment in England with great success. Patients must be sedated sufficiently so that they do not respond to verbal stimulus, only pain stimulus. This level of unconscious state is necessary for my patients.

77 She believed Dr Sargent used shorter periods of sedation and that the sedation was nowhere near as deep as in DST. She said that after this she made complaints to Dr Gill about the use and quantities of medications in the DST treatment, the frequency of ECT given, the lack of (proper) examination of patients before DST treatment commenced, and the amount of medical staff with adequate training present at Chelmsford. She found Dr Gill’s response inappropriate as he would seem to be highly amused and laughed or brushed it off and said words to the effect of: *you are overreacting, you are not familiar with the treatment and do not understand. The doctors know best. I think the staffing is adequate, I am only a phone call away.* She rejected the suggestion these conversations with Dr Gill did not occur, saying:

He was really the only person ... he was the owner and the administrator and my employer, and I ... felt he was the only person that I could say these sort of things to

openly, at that time.

...

A general discussion about what I was worried about? I felt that was more – very appropriate to talk to Dr Gill about. I don't know that I even mentioned specific patient names to Dr Gill, but certainly about the sedation and what was happening in there, and the risk of what could happen.

78 Her relationship with Dr Bailey and Mr Herron was also strained due to her complaints about DST and ECT at Chelmsford and patient care.

79 She said that she overheard conversations between other nurses about deaths that had occurred at Chelmsford, and “was struck by the number of deaths that had occurred ... From my experience, it was uncommon for there to be a large number of deaths at a psychiatric hospital. I became increasingly worried about what I had heard.” As a result of this concern, Ms Bothman accessed and read the hospital's death certificate book and she recalled that the causes of death recorded there “included coronary occlusion, myocardial infarction, pneumonia and coronary disease. I do not know whether all of these patients were treated with Sedation Treatment.” This was concerning to Ms Bothman as, in her experience in psychiatric nursing at other hospitals, “deaths in hospital were uncommon except for the occasional suicide and old age.” After this, Ms Bothman formed the view that “the patients at Chelmsford were dying at a young age and that the causes of death were unusual for persons of those ages and for a psychiatric hospital.”

80 She said that it was very common for DST patients to develop complications including pneumonia and other chest infections, DVT (deep vein thrombosis), urinary tract infections and bowel impactions. She said that:

...a few months after I started working at Chelmsford ... due to my concerns for the health of the patients, I instructed the nurses who worked in the Sedation Wards that where a patient's temperature rose to over 37.5 degrees nurses were to stop administering medication, lighten the patient out of sedation and move them to the General Wards. I gave that instruction because I had formed the view based on the responses to the concerns I raised ... that Dr Bailey, Dr Gill and Dr Herron did not perceive the risk to patient safety caused by elevated temperatures.

81 When she notified Dr Bailey of her intention to lighten a patient's sedation he ordered that she maintain the patient's sedation, or if she did not notify him before lightening he would direct another nurse to re-sedate the patient.

82 She had significant concerns about consent issues at Chelmsford. She said:

I understood that it was Ms Sansom's [the receptionist's] responsibility to get the

patient to sign the ECT consent form [upon admission] and I observed her do this ... To the best of my recollection the admission sheet did not require patients to sign their consent for Sedation Treatment ... From speaking to patients, reading the Nurses' Notes and my conversations with Dr Bailey, I formed the view that a lot of the patients admitted to Chelmsford for Sedation Treatment and ECT did not know that they were to have those treatments and did not know what Sedation Treatment nor ECT entailed. I recall several occasions when I called Dr Bailey to inform him that his patient had arrived at Chelmsford and he told me not to tell certain patients that they were going to have Sedation Treatment or ECT ... I think for a short period I did follow his instructions despite my reservations ... I was also aware from speaking to nurses at Chelmsford that Dr Bailey had told them, if a patient refused to sign the consent for ECT form or was not to be told that they were having Sedation Treatment, a nurse was to say to the patient words to the effect of: *Here is some medication to help you relax. You will feel a lot better after it*, and then give the patients Valium tablets. Once the patient was drowsy, the registered nurse or matron administered an injection of Sodium Amytal to the patient and he or she was transferred to the Sedation Wards.

...

...some of the patients replied with words to the effect of: *The treatment has not previously been fully explained to me by [Dr Bailey or Dr Herron], or, My doctor did not tell me that I was going to have sedation*. Some of those patients agreed to be admitted. Some of those patients said words to the effect of: *I don't want to be admitted. Please call my relative/friend and ask them to come and take me home*. When this occurred, I remember calling a cab, at the patient's request, to pick up the patient and contacting the patient's family by phone ... On these occasions, I did not notify ... Dr Bailey or ... Herron.

83 She rejected the suggestion that the patients were so psychologically incapacitated that they did not know what was going on. She said they were voluntary patients. It took her a while to realise just how little the patients knew about what was happening. She did not believe that patients were given "a detailed description of the fact that the patient was going to be unconscious for 10 days and at such a deep level. And that they [would] be having that number of ECTs. I don't think that was happening."

84 She was concerned about ECT at Chelmsford. In her psychiatric nursing experience prior to Chelmsford, ECT was given two or three times in total except in severe cases, and during ECT there was always an anaesthetist, psychiatrist and several nursing staff present, and sometimes a second doctor, when the treatment was administered. The standard procedure was:

- a) all voluntary patients provided signed consent prior to treatment;
- b) the patient fasted for at least 6 hours before ECT was administered;
- c) the anaesthetist gave the patient an injection of muscle relaxant and sedation (or general anaesthetic);
- d) an airway was inserted into the patient's mouth and tongue if required;
- f) a few puffs of oxygen were given to the patient prior to the administration of ECT;

- g) ECT was administered to the patient;
- h) the psychiatrist observed the seizure caused by the ECT;
- i) the doctor assessed the patient's condition after ECT and provided oxygen and suction as required until he or she started to recover;
- j) the patient was positioned on his or her side, in what is referred to as the unconscious position, to maintain respiration;
- k) the patient woke gradually;
- (l) nurses checked on the patient's recovery and took observations until the patient was awake enough to sit up in bed and be aware of his or her surroundings; and
- (m) the patient was given fluids and light refreshments.

85 At Chelmsford every DST patient was given ECT unless the doctor specifically ordered to the contrary. ECT was performed every day by Mr Herron or Dr Gardiner using an "ECT machine [that] did not have a regulator on it ... which meant that the doctors were unable to regulate the amount of voltage released by the machine and the duration of the shock." She said:

I recall the process at Chelmsford being that the operator ... kept administering ECT until the patient had a seizure. I had heard of this happening but had not seen it administered that way before. My concern was that administering ECT this way could cause fractures, damage to soft tissue from severe seizures, and pain due to the lack of anaesthetic ... When I first started at Chelmsford, I recall that generally patients were not given a general anaesthetic or a muscle relaxant prior to having ECT nor oxygen before and after ECT. I recall on one occasion in my presence, Dr Gardiner administered a series of ECTs until the patient's body lifted off the bed so that they were balancing on the back of their head and the heels of their feet and the patient screamed. When this occurred, the nurses had to hold the patient down. I concluded from the physical reaction of the patients when this happened that they could still feel pain ... I also recall witnessing cases where a patient who had been sedated for less than four hours was given ECT, which meant that he or she was not heavily sedated.

86 Ms Bothman also did not recall Mr Herron routinely giving oxygen to DST patients before ECT which concerned her, as the ECT seizure involves a reduction in oxygen, and it was standard medical practice to give oxygen to a patient after ECT until they started to breathe for themselves. She said that she raised her concern about the lack of use of muscle relaxants and anaesthetic with Dr Gill and that for a period after this the doctors administering ECT did start giving patients muscle relaxants and anaesthetic prior to treatment, but that it was her understanding "from reading the Nurses' Notes and speaking to nurses at Chelmsford that this practice was not maintained."

87 She resigned in January 1977 as she felt that she "could not accept responsibility for the patients receiving Sedation Treatment and that my concerns were not being dealt with."

88 I do not consider that Ms Bothman's evidence was other than honest. As the Matron of Chelmsford she had ample opportunity to know what was occurring in the DST ward despite not nursing there. She plainly made it her business to know. She did not say her evidence was influenced by the report of the Royal Commission. Her evidence was manifestly her recollections. There is no doubt Ms Bothman believed Dr Bailey, Mr Herron and Dr Gill were involved in a very dangerous practice and she was angry about this. She effectively accused Dr Bailey of the murder of one patient. None of this means that Ms Bothman was doing other than giving her honest recollections. To the extent that there are discrepancies and inconsistencies with earlier statements she gave I do not accept that they undermine the general validity of her evidence. Nor does the fact that Ms Bothman may have the sequence of events wrong undermine her overall credibility. Similarly, her perception of the ECT machine used at Chelmsford may be accepted to be based on mere observation rather than any detailed understanding of the functioning of the machine. This does not mean she did not observe what she said she observed. The applicants' submissions fail to confront the fact that errors, inconsistencies and inaccuracies are to be expected given the passage of time. They do not support a conclusion that Ms Bothman is a liar or involved in recent invention. The general thrust of her evidence is clear. She perceived numerous problems with the administration of DST and ECT at Chelmsford, sought to raise her concerns with Dr Bailey, Mr Herron and Dr Gill, and was effectively ignored.

#### **4.2.3 Noelene Brasche**

89 Dr Brasche worked as a registered nurse at Chelmsford for a period of around five months from about October 1973 to about February 1974, initially working two, and later three, night shifts per week. Dr Brasche completed her training as a general nurse at Lewisham Hospital in about 1967 and completed a post-graduate nursing course in cardiopulmonary disease at Royal North Shore Hospital in about 1969. Between 1967 and 1972 Dr Brasche worked as a general nurse in a psychiatric/geriatric hospital, a clinical nurse at St Vincent's Hospital in Sydney, and a clinical nurse educator at St George Hospital. After leaving Chelmsford she continued to work as a nurse until her retirement in 2010, mainly in palliative care and palliative care education, and also worked for 16 years as a community nurse, and from 2006 to 2010 as nursing educator of the mental health department of Hornsby Hospital.

90 Dr Brasche said she still had a good memory about Chelmsford. During her shifts there was no doctor on duty and she was the only trained nurse, and that generally there were also at least

two nurses' assistants, who acted under her direction. The training was fairly minimal and mostly involved observation in her first week. There were between six and 12 patients receiving DST. She said:

Every four hours, I would administer sedatives to the patients in the DST Ward through a Ryles tube. I understood that the amount of sedatives that I was required to give to the DST patients was set pursuant to a fixed regime, which was 200 to 400mg of Tuinal, which could be varied at my discretion ... I recall there being typed drug sheets kept at Chelmsford for each DST patient, setting out the drug regime, each of which were identical. ... I also recall that, in between the administration of Tuinal every four hours, the DST patients were administered with either Seranace or Neulactiul, although I cannot recall in what dosages, and this was only if the patients became rousable ... At the same time as administering the sedatives as referred to above, I would also feed the DST patients through the Ryles tube, ordinarily with Sustagen.

91 She gave this evidence:

And in relation to actually seeing the patients, it's right, isn't it, that the patients would at least be eyeballed by either you or one of the assistant nurses at least every half an hour?---No. I wouldn't actually say that. If the ward was quiet ... the idea was to have them sedated, we were outside the ward, but we were vigilant to all changes in sound. I mean, we were in and out, but, I mean, there – once you had done your – the rounds, the idea was to let them then settle. But, you know – yes. I would certainly say every hour we would be in.

And is it right that sometimes it wasn't quiet, and some of the patients were quite restless?---Occasionally that happened, but it didn't happen very much on my watch. Yes. They could become a – a little restless, but within what you would consider to be reasonable in terms of – you know, when somebody is in a deep sleep, they can quite often thrash about and be restless. So as long as it was within, you know, something which is acceptable, normally acceptable when somebody is in a very profoundly deep sleep, then again they can murmur and, you know, snore of course. There was any amount of that. So – but you could – a trained eye can always pick if someone is restless, because there is some other reason for their restlessness. They're uncomfortable, they're in pain, they're having difficulty breathing or anything like that would be immediately obvious. But, you know, people can be restless when they're asleep.

92 Dr Brasche also said:

Generally, if a patient was rousable in between the four-hourly administration of Tuinal, I was instructed to deepen their sedation by administering other barbiturates. I recall on several occasions being told by Matron Robson words to the effect of: *You had the patients too light, you have to keep them deep.*

93 She may have withheld the four hourly dose of Tuinal if the patients were “profoundly deep” because of her concerns about safety. That decision was in her discretion. She would also withhold the drugs if the patient showed signs of respiratory difficulties.

94 She said that when she was employed Matron Robson told her that in an emergency “the procedure is ... to call Dr Gill at his home in Wahroonga, who will come ... and decide whether

they need to go to another hospital. You cannot send a patient to hospital without contacting the doctor.” She was not comfortable with this as:

...if a patient was in respiratory distress, they needed to be intubated very quickly, or else there was a risk of serious harm or death. Chelmsford did not have equipment or personnel capable of intubating a patient, which would have to be done at the closest hospital to Chelmsford, which was Hornsby Hospital ... Wahroonga was at least a 15-minute drive from Chelmsford. I believed that waiting at least 15 minutes for a doctor to attend Chelmsford to assess a patient who was in respiratory distress was not good medical practice, and would place the patient at an unnecessarily high risk of serious harm and probable death. At some point about a month after my conversation with Matron Robson as referred to above, I said words ... to the following effect: *It's not safe to have to call Dr Gill if a patient is ill. If that happens, I'll be calling an ambulance directly.* Matron Robson and I had a number of argumentative conversations in my final few months at Chelmsford in similar terms.

- 95 She said that the DST ward, and Chelmsford generally, “did not have any emergency hospital equipment ... an oxygen tank and mask and an electric sucker ... [were] used to remove mucus from the patients’ mouths while sedated”, and that towards the end of her time at Chelmsford the hospital acquired a Bird’s Respirator, equipment Dr Brasche was familiar with from her time working as a clinical nurse at St Vincent’s Hospital. However, the Bird’s Respirator was unsuitable as it required the patient to be intubated and this could only be done by a doctor and was beyond the skills and training of a nurse, and there was no doctor on duty at Chelmsford.
- 96 She said that Mr Herron gave patients ECT without giving them a muscle relaxant which she understood should not occur as it could lead to muscle damage during a seizure. She said that she insisted to Mr Herron he use a muscle relaxant while she was assisting in ECT.
- 97 She said that while employed at Chelmsford she voiced her concerns about “the practice of DST ... in particular the patient treatment and administration of drugs [which] seemed to me to be so unusual as to be outside the normal and accepted bounds of psychiatric treatment”. She raised her concerns with the NSW Nurses’ Association who advised that it was “fine to proceed” with the treatment at Chelmsford, if the treatment was in a registered hospital with registered staff, and was performed at the direction of a doctor. She also raised her concerns with her GP, who advised while there seemed to be strange treatments there, the Health Department seemed to “approve”, and that if she was uncomfortable she could cease working. She did in fact quit working at Chelmsford.
- 98 I do not accept the applicants’ criticisms of Dr Brasche’s evidence. The alleged inconsistencies with her evidence to the Royal Commission are not material and are explicable by the usual processes of answering specific questions in different situations. I do not accept that her



evidence consisted of recent invention. She struck me as an honest witness recalling her time at Chelmsford. She may have had some of the details wrong (there was more equipment in the DST ward than she recalled) but this does not mean she was a liar or that she considered the equipment adequate at the time. She plainly did not. I accept the general effect of Dr Brasche's evidence. The fact that Mr Herron administered ECT on occasions with Dr Brasche as his assistant without giving a muscle relaxant does not mean that she did not raise her concern about this with Mr Herron. She may be misremembering the effect of her complaint to Mr Herron (that he used a muscle relaxant when she was assisting) but she has good reason to recall such a conversation and I accept it happened.

#### **4.2.4 Marcia Fawdry**

99 Ms Fawdry spent most of her working life as a nurse. Commencing her training at the Gladesville Hospital in 1963 Ms Fawdry was registered as a psychiatric nurse in 1968. In about mid-1972 Ms Fawdry began employment at Chelmsford. Prior to taking maternity leave Ms Fawdry worked from Monday to Friday on a 9am to 3pm shift. During that period Ms Fawdry was doing activities and group therapy but was not involved in DST. After returning from a three to four month maternity leave period Ms Fawdry was on night duty as the only registered nurse. Ms Fawdry continued working the night shift for about four years. Following this Ms Fawdry returned to the day shifts but continued as a registered nurse. In 1977 Ms Fawdry was appointed as the Matron at Chelmsford. Ms Fawdry continued in this role until about June 1978.

100 Ms Fawdry said she only admitted a few patients. After admission the patient was given an injection of sodium amytal to sedate them before being transferred to the DST ward. Patients were constantly assessed but every four hours the patients were starting to lighten up which meant the previous dose of drugs was wearing off. The nurses would take a four hourly set of observations including blood pressure, temperature and pulse and they would change the patients if they were wet, change their position and provide the appropriate nourishment. There was a standard sheet which had to contain a doctor's signature for the nurses to administer drugs. Dr Bailey and Mr Herron did not adjust the treatment sheets according to the particular physical or medical conditions of the patient. There was a degree of discretion left to the registered nurses as to the amount and timing of drugs given to each patient but she understood both Dr Bailey and Mr Herron liked to keep the patients asleep.

101 Mr Herron and Dr Gardiner came in to give the patients ECT. When Ms Fawdry was on night duty she assisted Mr Herron in the giving of ECT nearly every night to patients. Ms Fawdry said that when Mr Herron was administering ECT he did not give the patient a muscle relaxant or anaesthetic. She recalls that on some occasions an ECT consent form was not signed yet nevertheless ECT was given. Ms Fawdry stated that Mr Herron conducted such ECTs and remembered nurses raising this with Mr Herron to which he would reply words to the effect of “I will give my authority”.

102 She saw Dr Gill as the owner of Chelmsford and if she ever had an issue she knew she could speak to Dr Gill.

103 Ms Fawdry recalled an occasion where she, Dr Gill, Mr Herron and Mollie Sansom (the receptionist) were in the Matron’s office discussing Mr Hart. To the best of her recollection the conversation in the Matron’s office was as follows:

In that conversation [it] was being discussed about how they could disguise the fact that Barry’s ECT wasn’t signed. The ECT authority was on the bottom of the identification sheet - the front page of the notes, and so it was sort of, like, I guess, a half an A4 size, and that wasn’t signed. So I can recall someone suggesting that perhaps we could - they could put a pathology report over the top of it to disguise the fact that that particular form wasn’t signed for.

104 In explaining why she denied the existence of this conversation to police Ms Fawdry said:

I was very reticent to be part of anything that was going to threaten my registration. I was working as a registered nurse, I was a sole parent with three children, and I didn’t actually lie, but I just didn’t expand on the truth and I dodged around the issue so that I didn’t have to talk about it at all.

105 She also denied the conversation to Mr Herron when he called her but she did not know she was being taped by Dr Gill at that time. She said the first time she ever told the truth about the conversation was at the Royal Commission because she did not have much to lose by then. Her children had grown up and she was in secure employment. Before that she thought she had done something wrong by being present during the conversation but by the Royal Commission she knew she had not done anything wrong.

106 Ms Fawdry considered the nursing at Chelmsford to be of a high standard. She agreed that if a patient was to defecate in the bed they would be changed immediately. Chelmsford was a voluntary hospital and the doors were not locked. She said some patients were very restless before the end of four hours from receiving a dose of drugs and would try to get out of bed or remove their Ryles tube. She felt she was working within her capabilities. In her view there

was adequate monitoring of patients by the nurses and the equipment in the sedation ward was adequate for the purposes of treating the sedated patients. She agreed that when a patient was admitted a nurse took a history from the patient, took their observations including weight, respiration, cardiovascular, temperature, blood pressure, pulse and urinalysis, and told the patient what was going to happen next including what treatment they were going to have.

107 She admitted she detested Dr Gill and was “pissed off” with Mr Herron about the taping of the conversation. She denied concocting the story about the conversation relating to Mr Hart’s consent form.

108 The applicants accepted that Ms Fawdry was a generally honest witness, as do I. This does not mean I accept her evidence that the nurses at Chelmsford were able to provide safe care to the DST patients or that the equipment was adequate for that purpose. Ms Fawdry was not sufficiently qualified to provide these opinions. She did not understand the risks associated with DST, nor that there was no medical justification for it, so that no safe level of care could be provided to patients undergoing it. Despite accepting Ms Fawdry’s general honesty the applicants contend she lied about the meeting concerning Mr Hart’s consent form. I found her explanation for her inconsistent evidence over time about that conversation to be wholly persuasive. I have no doubt she is telling the truth about that conversation. The applicants’ submissions to the contrary simply do not confront the nature of Ms Fawdry’s testimony – she was a frank and honest witness in all respects. She was open about her previous attempts to evade giving evidence about the conversation and her reasons for doing so. The fact that she may prefer to characterise her conduct as involving evasion rather than dishonesty is part and parcel of the ordinary human experience. It does not mean that her evidence in this proceeding is unreliable. I consider that Mr Herron’s and Dr Gill’s repeated denials of the conversation are part of a pattern of untruthfulness on their part in respect of anything they consider adverse to their version of events – namely, that there was no problem with the administration of DST and ECT at Chelmsford.

### **4.3 Former patients and their relatives**

#### **4.3.1 CO**

109 CO was married to RCO who developed a heroin addiction prior to being admitted to Chelmsford.

- 110 In about September 1977 CO attended Dr Bailey's rooms in Macquarie Street with her husband. CO recalled being told by Dr Bailey that he could cure her husband's heroin addiction and had a very high success rate. CO did not remember Dr Bailey explaining the treatment that her husband would receive including that he would get ECT. After seeing Dr Bailey, CO drove her husband to Chelmsford. CO was told by the nurses that she was not allowed to see her husband when he was sedated as it was out of bounds. In the following 14 days CO attempted to visit her husband but was told by the nurses that her husband was in sedation and she was not allowed to see him. Approximately two weeks after her husband's admission CO received a telephone call telling her that her husband was out of sedation and she could visit. CO recalls seeing her husband lying in a bed with wet cloths on his face and a fan blowing on him. She stated that her husband looked like a skeleton. Following his discharge CO observed that her husband started using heroin again within a few days.
- 111 Her husband was admitted to Chelmsford on two more occasions and received DST both times. On discharge he would use heroin again. During her husband's penultimate admission to Chelmsford CO remembered receiving a telephone call from a person that she knew was a nurse at Chelmsford. CO stated that the nurse said to get her husband out of there right now. CO immediately drove to Chelmsford and discharged her husband. On the final admission CO recalled her husband looking like a walking zombie as he was stiff and vacant. CO and her family were due to take a two week holiday in Queensland following her husband's final discharge, however, two days into the holiday CO remembered taking her husband to a doctor as he was not speaking and struggled to walk. CO recalled the doctor saying that she should take her husband home and not to see Dr Bailey. Once they were back home CO took her husband to their local GP. RCO was physically examined and CO remembered being told by the GP that her husband was catatonic. RCO was subsequently admitted to a rehabilitation centre for drug users and people experiencing mental illness.
- 112 CO recalled that after her husband had DST he was too weak to stand up and walk by himself and she had to help him. She said he became a different person after Chelmsford. He stopped working (when before he had always been a very conscientious worker despite the heroin addiction), became vague, and unable to concentrate. His memory became terrible and he seemed to stop caring about his appearance and what others thought of him. She said she did not know he had ECT at Chelmsford until the Royal Commission.

113 The fact that CO could not recall the sequence of her husband's admissions to Chelmsford does not mean that the general effect of her evidence is unreliable. I accept that she was giving honest evidence about her recollections of the impact of DST and ECT on her husband. It is plain that the treatment involved no benefit and caused her husband ongoing serious harm.

#### **4.3.2 John Finn**

114 In the first half of 1975, when Mr Finn was 18 years old, he was suffering from depression and anxiety. In about August of the same year Mr Finn was taken to Chelmsford by his aunt. His aunt told him that she had been treated there by Dr Bailey. Mr Finn recalled that upon arriving at Chelmsford he was told by a nurse that he would be put to sleep for a few days. Mr Finn was not asked to sign any forms (he did but has no recollection of doing so), was not told anything about the treatment that he would receive, was not told that he was going to receive ECT, was not physically examined or asked about his health, or seen by a doctor.

115 He was shown to a room and given some pills. He became semi-conscious. He could not move or communicate but was aware of things around him. He was strapped to the bed tightly. He was fed through a tube. He remembers patches being placed on his head on a number of occasions with great bolts of electricity zapping him through the patches. Mr Finn felt like he was dying and each time he was zapped his mind and body went into a great painful darkness.

116 When regaining consciousness he had vivid hallucinations of severed body parts hanging from the roof around his bed. He estimated that he had lost 10 kilograms. It took him two weeks to be able to walk properly. After he was discharged his anxiety was worse and he had panic attacks.

117 He returned to Chelmsford two months later and requested ECT. He was taken to a room and seen by a doctor whom he understood to be Mr Herron. Mr Herron gave him an injection which made him unconscious. When he woke up his arms and legs were shaking uncontrollably.

118 Mr Finn accepted that his recollection of details was not good but said that certain things stuck in his memory – having the hallucinations of body parts on hooks, being fed by tube, chewing his way through leather straps, being lifted back into the bed.

119 For many years after his treatments at Chelmsford Mr Finn suffered debilitating panic attacks, which were brought on by the memories of receiving ECT. The panic attacks were so severe that it would take Mr Finn months to get over them, during which time he could not work. Mr Finn also has quite bad memory loss from around the time of his admissions to Chelmsford

and shortly thereafter. Mr Finn stated that a large part of his life was taken away because of his treatments at Chelmsford and it is only with the help of his family and friends that he has been able to recover.

120 I do not accept that Mr Finn’s evidence was recent invention. It is apparent that his memory of events was imperfect. But he recalled some things about his treatment and was clear about its effect on him, specifically that the treatment he got at Chelmsford made him worse than he had been previously. The fact that Mr Finn was involved in the Chelmsford Victims Action Group does not mean his evidence is tainted or has no value. I accept his evidence that his treatment at Chelmsford did him no good and instead caused him serious and continuing harm.

#### **4.3.3 GW**

121 GW is a retired psychologist. GW completed a Bachelor of Arts, a Master of Education in Educational Psychology and a Master of Arts in Psychology. GW worked as a school counsellor with the New South Wales Department of Education for several years and then as a student and staff counsellor at the University of Sydney for 25 years.

122 GW was referred to Dr Bailey in about 1969. She was depressed as she was experiencing marriage difficulties. Her husband was a heavy drinker, abusive, manipulative and controlling and GW was unable to see a way out of the marriage. When GW first met with Dr Bailey, GW recalled being prescribed a number of drugs. GW saw Dr Bailey monthly for several months. Later in 1969, GW overdosed on the drugs prescribed by Dr Bailey and was admitted to St Vincent’s Hospital. After a few days there GW was transferred to Chelmsford.

123 GW had a vague recollection of arriving at Chelmsford. GW remembers being told to “take this, it’s just something to relax and help you sleep”. After this, GW’s memory was blank. GW then recalled regaining consciousness some two or three weeks later. GW was very distressed, depressed, confused and disorientated in the time following regaining consciousness. Terrified and wanting to go home, GW remembered thinking that she had lost a lot of weight. GW was to later learn that she lost some 2 stone during admission at Chelmsford. At the time of writing her affidavit in September 2019 GW understood that the treatment she received was DST.

124 Following discharge from Chelmsford, GW continued to see Dr Bailey about monthly. GW began to have issues with anxiety and felt very dependent on the drugs that Dr Bailey had prescribed. GW was admitted for a second time to Chelmsford in approximately 1970. GW

was treated with DST again. Whilst GW recalled little of that admission, GW believed that it was following another overdose on the drugs prescribed by Dr Bailey.

125 GW recalled aspects of her time at Chelmsford but could not identify which admission the memories concerned. She recalled being in a room, strapped to a bed and unable to move, seeing other people also strapped to beds, all unconscious, and hearing screaming, speaking to her mother on the telephone and asking to be taken home, and feeling completely disconnected from everyone and everything.

126 Before her time at Chelmsford GW said her memory was excellent. Afterwards, her long and short term memory has been severely impaired. GW stated that she suffers from crippling anxiety, has suffered a number of panic attacks, and is more inclined to irritability since her admissions at Chelmsford. GW still experiences flashbacks which cause feelings of shame, anxiety, humiliation, entrapment, neglect and a total loss of power and control. GW believed that these feelings will never leave her; they haunt her.

127 She agreed that she had told the Royal Commission she felt like she had been imprisoned at Chelmsford and was prevented from phoning her family. She said it felt like she had no control and no contact with the outside world. She did not recall visits from her mother or husband. She said she found out after she left Chelmsford that she had been given ECT. She believed ECT had been given to her without her consent.

128 She disagreed that she had anxiety before her time at Chelmsford. She had herself admitted there in 1972 because she did not know where else to go. She said that her evidence to the Royal Commission that she went there because she felt safe was a result of her feeling very traumatised.

129 I do not accept the applicants' submissions that GW was intent on blaming Dr Bailey for her pre-existing problems. She clearly perceived that her treatment at Chelmsford had caused her life-long trauma and harm and there is no reason to doubt that she left Chelmsford in a state of trauma which has continued over the years as a result of her treatment there. The fact that GW had experienced psychiatric issues before seeing Dr Bailey does not mean that her treatment at Chelmsford caused her no harm. Her evidence of life-long trauma due to what happened to her at Chelmsford was compelling. Her involvement with the Chelmsford Victims Action Group also does not mean her evidence was unreliable.

#### 4.3.4 CW

- 130 In 1969 CW was admitted to Wolston Park Psychiatric Hospital in Brisbane for recreational drug abuse having used opiates for three months. During her time there CW recalls seeing women receive ECT and thought they looked like “zombies, almost vegetables, they were in an appalling condition, seemed to have lost all their faculties and to be completely unaware of their surroundings”. From this experience CW was convinced that ECT was to be feared and avoided at all costs.
- 131 In 1970, CW was intermittently using drugs and was admitted to Wisteria House Parramatta. Following discharge, CW continued intermittently using drugs but remained in full time employment and in a stable domestic relationship. In 1973 CW found out she was pregnant and was at the Crown Street Women’s Hospital where she met with Dr Bailey. At the same consultation, Dr Bailey discovered CW’s drug abuse history and suggested DST. CW recalls meeting with Dr Bailey two further times at the Crown Street Women’s Hospital. CW stated that at no time during any of the consultations did Dr Bailey give a detailed explanation of DST, nor did he explain the side effects. CW remembered that Dr Bailey did not tell her that she would receive ECT during DST.
- 132 CW’s memory of her admission to Chelmsford in June 1973 was patchy. She recalled being in a nice clean hospital bed with white sheets and taking two tablets, a person asleep in the next bed, a nurse attending on her and that paperwork was involved, and that she refused to sign the ECT permission form. Her next memory was being in a bath and being cleaned by someone she did not know. CW was distressed, disorientated and felt physically debilitated. CW did not know why she was there and recalls not responding to her name as she did not recognise it. Instead, CW believed her name to be Maggie Tilley. It transpired that Maggie Tilley was the name of another patient with whom CW shared a two-bed hospital room. CW gave evidence that she now understood that this experience was three weeks after she took the two tablets.
- 133 CW explained that the room she was in led onto a corridor that was full of locked doors. CW recalled it feeling like a prison. When asking to use a telephone to call her partner, CW said that she was not allowed and that it was located on the other side of a locked door. At some point CW did get access to the telephone but when she spoke to her partner she broke down in tears and asked him to come get her. CW recalled a nurse immediately taking the phone from her and terminating the call. CW believed she escaped from Chelmsford, but did not know whether she was helped or not. Her memories of the entire time were patchy although bits and



pieces had come back over the intervening years. CW stated that around the time of the Royal Commission she spent a great deal of time trying to piece together what she could remember of her life around the admission to Chelmsford.

134 After CW left Chelmsford she recalled receiving an unexpected bill for special nursing treatment. CW vaguely remembered calling Chelmsford and being told that the charges related to pneumonia that she had suffered during her admission. This was the first time CW was aware that she had suffered pneumonia whilst at Chelmsford. Further, around the time she was giving evidence at the Royal Commission, a woman employed by the Royal Commission showed CW a number of notes from Chelmsford in relation to her admission. One of those notes was a pink sheet of paper which had “do not give me ECT” written on it a number of times in CW’s handwriting.

135 Prior to her admission to Chelmsford CW never had any issues with her memory, with chest infections, bronchitis or pneumonia. Her memories of Chelmsford were very fragmented, transitory, sparse and vague. CW gave evidence that she had total blank periods just prior to and from about 2 years after her admission to Chelmsford. In the two years following her discharge from Chelmsford CW suffered from pleurisy and was hospitalised a number of times suffering from pneumonia. From about 1975 to 1985, CW also suffered regular episodes of bronchitis, sometimes up to six times a year. These episodes continued from 1985 to 1995 with CW being diagnosed with asthma in 1990. CW did not work again for five years after her admission to Chelmsford.

136 CW gave evidence that to this day she suffered great anxiety and stress from her time at Chelmsford. She did not know what happened to her and she remained very angry about her treatment, particularly that she was given ECT against her very clearly stated wishes. CW felt like she was not the same person after being admitted to Chelmsford. She felt like she lost her vitality, her natural inquisitive nature and her interest in doing anything.

137 She accepted that she had told the Royal Commission she had no memories of the admission process but said she did have some memories. She said that her evidence to the Royal Commission that she was not particularly in favour of ECT was an understatement. She denied having hallucinated about the pink sheet of paper but accepted it had never been located. She accepted that she had a serious drug problem before her admission to Chelmsford and had been charged with breaking and entering. She agreed she was a smoker of about 40 cigarettes a day until the early 1980s.

138 It may be accepted that CW was wrong about the wards being locked. But what cannot be doubted is that she felt like a prisoner and was traumatised by what occurred at Chelmsford. The fact that CW did not complain about Chelmsford until the Royal Commission does not undermine the substance of her recollections of having felt imprisoned and having been traumatised by what occurred at Chelmsford.

#### **4.3.5 Ernest Nam**

139 Mr Nam gave evidence about his wife's admission to Chelmsford. In or around 1972, after coming home from work, Mr Nam noticed that his wife did not seem to be herself. She was sitting in a chair and staring off into space. Mr Nam was concerned for his wife, so called an emergency doctor, who after examining Mrs Nam said that she was probably having a nervous breakdown. Mrs Nam continued to not be herself so Mr Nam called his wife's sister who suggested that Mr Nam consult a private nurse. That same day Mr Nam spoke with his cousin who told him of Dr Bailey. After speaking with Dr Bailey on the phone shortly after this Mr Nam drove his wife to Chelmsford. Mr Nam recalled being greeted by nurses at the reception and, as his wife was very tense and unable to properly sign any documents, he signed on her behalf. Mr Nam stated that he remembered being told by one of the nurses that they were "going to sedate her and put her to sleep to calm everything down". Mr Nam recalled his wife being taken to a hospital room where a nurse injected her with a needle in the upper thigh. Mrs Nam lost consciousness shortly after.

140 Mr Nam stated that a nurse told him "not to bother coming to see her because she will be sedated for a week". At approximately 7pm the following day Mr Nam attended Dr Bailey's offices in Macquarie Street. Mr Nam recalled seeing a man that he understood to be Mr Herron walk passed reception, take a file out of the cabinet and place it on to top of the cabinet. Dr Bailey then walked into the reception, picked up that file and called Mr Nam into his office. When in Dr Bailey's office Mr Nam remembered being told that his wife had just passed away as she had had a cerebral haemorrhage. According to Mr Nam, Dr Bailey said that they "woke her up at 7, she had a cup of tea, and then she died at 7.30". Two days later when Mr Nam went and saw his wife's body in the funeral home he distinctly remembered that she had very heavy bruising around the sides and back of her neck.

141 Mr Nam acknowledged that he was told by Dr Bailey that his wife would be sedated which Mr Nam believed to be for about a week. Mr Nam disagreed with the suggestion that Dr Bailey told him that he would be giving his wife ECT. He accepted that he had said in the Royal

Commission that he assumed the bruising he saw on his wife's neck had been caused by shock treatment. He had said:

All he said was he was going to put her to sleep and I don't know whether the shock treatment was brought into it or not. It could have been. That's why I accepted the bruising on her neck. So somewhere in the back of my mind there could have been, I'm sorry.

142 He said he had a conversation with Dr Bailey where he was told it was no good dropping over to visit his wife because she would be asleep and would not know he was there.

143 I generally accept Mr Nam's evidence. If ECT had been mentioned to him then it seems to me it must have been in passing. He was also clearly not told about the details of DST or the risks it involved.

#### **4.3.6 General**

144 The applicants made wide ranging attacks on the credibility of these witnesses, blaming their unreliability on their pre-existing psychiatric conditions, sedatives they were given as part of DST, and their subsequent involvement with the Chelmsford Victims Action Group, as well as noting the lack of contemporaneous complaint and the effect of adverse publicity about Chelmsford on their thinking. These allegations do not confront the reality of DST and the harm that it was capable of causing and did in fact cause. None of the applicants' criticisms undermine the essential thrust of the evidence – that for no sound medical reason and without their informed consent patients were subjected to a dangerous ordeal that many found terrifying and traumatising.

145 I accept the submissions of the respondents about the evidence of these lay witnesses to the following effect:

The Applicants have made lengthy submissions about the lay witnesses called by the Respondents in these proceedings. The thrust of those submissions, particularly in respect of Mr Finn, Ms CW, Ms GW and Ms [CO], is that every single one is wholly unreliable because their evidence does not precisely accord with contemporaneous documentary evidence.

Insofar as there is any discrepancy between the evidence given and matters recorded in documents, those discrepancies are minor chronological matters of little significance. The substance of the evidence given by the witnesses does not affect the substance of the evidence given of a callous, ineffective and terrifying treatment.

Moreover, each of Mr Finn, Ms CW, Ms GW and Ms [CO] came before this Court without any agenda. They received no inducement for giving evidence and knew full well that they would not be rewarded for doing so. It was painfully obvious during their cross examinations that the memories they were forced to recall were harrowing.

Submissions by the Applicants in respect of the credit of each of these witnesses should be rejected outright.

#### **4.4 Reputation witnesses for Dr Gill and Mr Herron**

##### **4.4.1 Virginia Gill**

146 Mrs Gill has been married to Dr Gill for 52 years.

147 She said that since the publication of the Book she observed a change in Dr Gill that she had not seen since the Royal Commission and the subsequent proceedings to which it gave rise were resolved. Mrs Gill stated that Dr Gill had become extremely irritable, anti-social and isolated since the Book was published. He no longer wanted to interact with friends or attend social events. Mrs Gill said that she observed Dr Gill to be particularly angered that Mr Cannane did not contact him for a response, seek information outside of Scientology aligned sources, or acknowledge that the courts stayed criminal and disciplinary proceedings against Dr Gill for a number of reasons. Mrs Gill and Dr Gill had spoken about the Book on a number of occasions with Dr Gill stating words to the effect of “this books makes it seem like I am a criminal”. To Mrs Gill’s observation, the people who know Dr Gill did not treat him any differently in the 20 years prior to the publication of the Book and he maintained his reputation as an upstanding businessperson and dedicated family man.

148 She agreed that terrible things had been said about Dr Gill in the Royal Commission. He was angry and very hurt by the Royal Commission findings but those feelings did not come up again until the Book was published. They had put the Royal Commission behind them but Mrs Gill stated that the Book really “shook us up”.

149 I generally accept Mrs Gill’s evidence to the effect that the publication of the Book caused Dr Gill significant distress.

##### **4.4.2 Margaret North**

150 Mrs North is Dr Gill’s sister. To her observation Dr Gill had a reputation of being honest and trustworthy and as being someone people came to for support, advice and even financial assistance. Since the publication of the Book Mrs North stated that she had seen Dr Gill become upset and angry because of the way he had been portrayed. Whilst Mrs North could not remember the precise details of the Royal Commission findings that were critical of Dr Gill, she was aware that he was severely criticised in the Royal Commission report. The criticisms of the Royal Commission had been devastating to Dr Gill and he was angry about them because

he felt they were incorrect. His hurt and anger had not lasted for 30 years, however, but when the Book came out he was very upset.

151 I generally accept Mrs North's evidence.

#### **4.4.3 Roger Wilkinson**

152 Dr Wilkinson is a retired cardiologist and has known Dr Gill since 1963. According to Dr Wilkinson members of his and Dr Gill's mutual social and professional circles shared the opinion that Dr Gill had a reputation of integrity and honesty both during the Royal Commission and after. To Dr Wilkinson's observation the publication of the Book had caused Dr Gill great angst and upset and Dr Wilkinson believed that Dr Gill was deeply disturbed that he had been painted as criminal, grossly negligent and dishonest when there had never been any criminal, civil or disciplinary findings of this nature against him. He knew the Royal Commission had made severe criticisms of Dr Gill including the following finding:

Gill was a most unsatisfactory witness. He was prepared to lie when the occasion demanded it. He ultimately continued his delusional attacks on innocent people in the witness box in the face of clear evidence he was wrong. He was prepared to indulge himself in the falsification or removal of records if his interests were threatened.

153 He did not agree with that finding. He had never heard similar criticisms of Dr Gill outside of the Royal Commission. He said that amongst the medical professionals that he mixed with, and that had been associated with Dr Gill, Dr Gill's reputation had not been sullied or tainted in any way following the release of the Royal Commission report. He agreed, however, that he did not know of any doctor other than Dr Gill who thought other than that the medical treatments at Chelmsford were discredited and dangerous. He agreed that the Royal Commission made serious adverse findings against Dr Gill and that the Royal Commission report received significant publicity. He accepted that it is notorious within the psychiatric community in Australia that the practice of DST at Chelmsford, including by Dr Gill, involved the mistreatment of vulnerable patients by the provision of dangerous, non-evidence based treatment, being DST, and said he suspected this was the view held by the medical community generally. He agreed that Dr Gill's behaviour at Chelmsford was part of a deeply shameful aspect of the history of psychiatry.

154 I generally accept Dr Wilkinson's evidence.

#### **4.4.4 Richelle Herron**

155 Mrs Herron is Mr Herron's daughter-in-law. She has known Mr Herron since 1989. She worked as his secretary in 1995. She did not recall Mr Herron's patients referring to Chelmsford or the Royal Commission. She said very few people she met today knew about Chelmsford or the Royal Commission. The publication of the Book caused tension. Mr Herron's trauma associated with the Royal Commission and related proceedings flared up again and Mr Herron became depressed, withdrawn, isolated and short-tempered. She had noticed Mr Herron drinking a lot more, fatigue in his voice and that he lacked energy and slumped. In the past Mr Herron led an active social life in his local community participating in a wood-working club and a wine club, but that since the publication of the Book, Mr Herron no longer attended those groups.

156 She agreed he was devastated by the Royal Commission findings and that he continued to be upset and hurt whenever he was reminded of the Royal Commission. The Book had reminded him of the Royal Commission when, before that, it had not been mentioned for years.

157 I generally accept Mrs Herron's evidence.

#### **4.4.5 Brendon Herron**

158 Brendon Herron is Mr Herron's son. He was concerned when his daughter wanted to pursue a career in mental health given her last name but when he spoke to friends about it they had not heard of Chelmsford. Among family and friends Mr Herron's reputation is as a loving and caring grandfather who has been very involved in his grandchildren's lives. After publication of the Book his parents started to drink heavily, argue, and were short-tempered, but before publication his father was jovial and relaxed and took great pleasure in hosting and catering family events. Brendon Herron stated that Mr Herron now lacks confidence and is quite emotional. In the past, his father led an active social life in his local community, participating in a wood-working club and a wine club, but that his father no longer attends these groups.

159 He agreed the Royal Commission findings had significant publicity and his father was hurt and angered by the findings. However, he would not say this hurt and anger had persisted continually to the present day. From time to time in social situations his father would be reminded of those events and be hurt and angry. He agreed his father was also hurt and angry when he was deregistered as a medical practitioner but said things settled down when they moved to the Central Coast.

160 I generally accept the evidence of Brendon Herron.

## **4.5 Stephen Cannane**

### **4.5.1 Background**

161 Mr Cannane is a journalist who has worked in various roles in radio and television at the Australian Broadcasting Corporation (ABC) from 1995. Mr Cannane has written two books published by the first respondent, including the Book.

162 Mr Cannane worked regularly as a journalist for the ABC's Lateline program from about 2009 to 2016, during which time he researched and presented a number of stories on the Church of Scientology. After the first two programs, which aired in May 2010, received "polar opposite responses" from supporters and critics of Scientology, Mr Cannane's interest in Scientology was "piqued" and he went on to research and produce approximately 10 more stories on Scientology for Lateline between 2010 and 2015.

163 Mr Cannane formed the view that his research could be the basis of a book about the "unique Australian story to tell about Scientology", and agreed with HarperCollins in or about 2011 or 2012 that he would write, and HarperCollins would publish, a book about Scientology in Australia, which became the Book.

### **4.5.2 Writing the Book**

164 Prior to commencing research into the Book, Mr Cannane was aware of the links between Scientology and the events at Chelmsford that led to the Royal Commission. This was drawn from *60 Minutes* programs and *Sydney Morning Herald* articles from the 1980s, an article in *The Monthly* titled "Only Itself to Blame: The Church of Scientology" in 2009, an article titled "The Big Sleep" in the *Sydney Morning Herald* in 2013 and archival ABC footage referring to Jan Eastgate and the Citizens Commission for Human Rights (CCHR, a group that works and operates inside the Church of Scientology). His focus was on the theory that Ms Nicholson, a nurse at Chelmsford, was planted there by the Church of Scientology to collect information and evidence damaging to Chelmsford, its psychiatrists and practices (referred to as the **Nicholson theory**).

165 He spent about four years researching and writing the Book. Mr Cannane's research for the Book involved over 200 interviews. Sources relevant to the Chapter included:

- (1) volumes 1 to 6 of the report of the Royal Commission report which he read across five days at the State Library of NSW;
- (2) newspaper articles regarding Chelmsford and the Royal Commission stored on microfiche at the State Library and available on the internet during the period December 2014 to early 2015. Mr Cannane also said that after being provided with a number of articles by his solicitors in these proceedings he recalled reading approximately 20 specific articles, including articles published in the *Sydney Morning Herald* in the late 1980s and early 1990s reporting on the Royal Commission (by journalists including Janet Fife-Yeomans, Annabel Dean, Robert Haupt and John O'Neill); articles from the mid-1990s about events leading to Mr Herron's disciplinary proceedings; and an article from 2009 relating to Mr Hart's legal suit against his former lawyers;
- (3) *Freedom*, a magazine produced by Scientologists marketed as "the Voice of the Church of Scientology in Australia, Oceania and New Zealand", which contained a story about the involvement of Scientology in exposing what occurred at Chelmsford;
- (4) *The Chelmsford Report: Australia's Greatest Psychiatric Disaster* published by CCHR in 1986;
- (5) *Deep Sleep: Harry Bailey and the Scandal of Chelmsford* by Brian Bromberger and Janet Fife-Yeomans, which Mr Cannane says he relied on for background information about Chelmsford;
- (6) the article "Deep Sleep Therapy and Chelmsford Private Hospital: Have We Learnt Anything?" by Marilyn Walton and published in *Australian Psychiatry*;
- (7) a number of books on Scientology, including biographies of its founder L Ron Hubbard; historical accounts of Scientology; memoirs by, and accounts of, former members' experiences in Scientology; and former members' critiques of Scientology;
- (8) parts of Hansard for the English House of Commons from the 1960s;
- (9) the programs relating to Chelmsford on *60 Minutes*;
- (10) a record of *The Coming Out Show* broadcast on 19 October 1985 which focused on Chelmsford and which Mr Cannane considered to be a report of what the medical practices at Chelmsford were and allegations made by former patients;
- (11) chapter 12 of *Menders of the Mind: A History of the Royal Australian and New Zealand College of Psychiatrists, 1946-1996* by WD Rubinstein and Hilary L Rubinstein (*Menders of the Mind*);



- (12) copies of sections of the transcript of the Royal Commission including the evidence of Rosa Nicholson, Jan Eastgate and Ron Segal. Mr Cannane also requested access to, but was unable to access, sections of the transcript including the evidence of Mr Hart and Toni Eatts;
- (13) the Court of Appeal judgment in *Hart v Herron*; and
- (14) conversations with a number of individuals associated with Scientology or Chelmsford.

166 Mr Cannane conducted various interviews relevant to the Chapter as follows:

- (1) on two occasions he interviewed Susan Geason who had written a manuscript about Chelmsford (**Geason Manuscript**), who gave Mr Cannane information supporting his theory about Ms Nicholson and gave him extracts of Royal Commission transcripts and interviews, and her handwritten notes. Mr Cannane considered Ms Geason to be a reliable source based on her thorough previous research. Mr Cannane read the Geason Manuscript and cited parts of it in the Chapter, where Ms Geason had spoken to sources who were unavailable to Mr Cannane, or accessed information that he assessed to be credible;
- (2) on two or three occasions he interviewed Mr Hart, who had been a patient at Chelmsford where he received DST. Mr Cannane recalls Mr Hart saying that he was treated with DST for 10 days by Mr Herron, after which he developed deep vein thrombosis and double pneumonia, that he wrote an autobiographical manuscript about his experiences (the **Hart Manuscript**), and successfully sued Mr Herron. Mr Cannane relied on information from Mr Hart to determine his experiences at Chelmsford and their impact on his life. Mr Cannane considered Mr Hart to be a reliable source because he was a former patient of Mr Herron, had been very involved in the push for the Royal Commission, and considered that “[d]ue to his fixation [on his experiences at Chelmsford]... he could strongly recall details about his treatment and the legal cases he was involved in.” Mr Cannane cross-checked Mr Hart’s information with the Royal Commission report and previous media statements, and, prior to publication of the Book, emailed Mr Hart a copy of the Chapter and “obtained his feedback about the accuracy of the matters relevant to him”;
- (3) he interviewed Margaret Como, Mr Hart’s carer and partner who met Mr Hart in the 1980s while working for NSW Parliamentarian Pat Rogan, whom Mr Hart lobbied to gain public and political attention about events at Chelmsford. Ms Como was involved

in Mr Cannane's discussions with Mr Hart and Mr Cannane also had separate conversations with her during which she said words to the effect that Pat Rogan's office "helped set up the Chelmsford Victims Action Group. I contacted the Sydney Morning Herald ... about Chelmsford, who then wrote stories regarding the atrocities at Chelmsford which helped to set up the Royal Commission". Mr Cannane considered Ms Como to be a reliable source;

- (4) on one occasion he interviewed Patrick Griffin SC, the solicitor acting for members of the CCHR at the Royal Commission, who gave Mr Cannane information relating to his theory about Ms Nicholson;
- (5) on two occasions he interviewed Ms Fawdry, who gave evidence at the Royal Commission, and gave Mr Cannane information relating to Ms Nicholson. Mr Cannane considered Ms Fawdry to be a reliable source, checked the information given by Ms Fawdry against extracts of the Royal Commission report and transcripts of evidence, and included quotes from his conversation with Ms Fawdry on pages 180, 184 and 194 of the Book;
- (6) on several occasions (separately) he interviewed Confidential Sources A and B, who Mr Cannane understood to be relatives of Ms Nicholson, who gave him information relating to Ms Nicholson;
- (7) on at least three occasions he interviewed Ron Segal, who worked as a pharmacist while practising as a Scientologist, was the head of the CCHR in the 1970s, gave evidence in the Royal Commission, and knew Ms Eastgate. Mr Segal gave Mr Cannane information supporting the Nicholson theory and provided him with Chelmsford hospital records, transcripts of interviews with Dr Smith and Sister Watson, articles regarding Mr Segal, the CCHR and Chelmsford in Scientology publications, and an article published during the time of the Royal Commission;
- (8) on dozens of occasions he interviewed Confidential Source C, a former Scientologist who worked as an undercover agent for the Guardian's Office, a division of Scientology, who gave Mr Cannane information relating to Ms Eastgate and the Nicholson theory;
- (9) on dozens of occasions he interviewed Peggy Daroesman, who Mr Cannane understood to be a former Scientologist and a member during the 1970s, and in contact with a large number of Scientologists;

- (10) he interviewed Confidential Source D, who Mr Cannane contacted after being instructed to do so by Ms Daroesman, who gave Mr Cannane information relating to the Nicholson theory;
- (11) on one occasion he interviewed Anthony McClellan, a director of the *60 Minutes* programs who told Mr Cannane words to the effect that “The *60 Minutes* program would never have been aired if not for the documents provided by Ms Eastgate”;
- (12) on a number of occasions he interviewed Vicki Dunstan and John Wells, the President of the Church of Scientology Australia & Asia Pacific and a publicist working for Scientology in respect of the Book, respectively. Mr Cannane’s evidence is that Mr Wells told him on the phone on a number of occasions words to the effect that Mr Wells was trying to get Scientologists to speak to Mr Cannane but they would not;
- (13) he interviewed Toni Eatts, a journalist whose interview with Ms Nicholson in the 1970s or 1980s had been evidence at the Royal Commission, but “did not rely on much of the information”, instead using a copy of her interview with Ms Nicholson; and
- (14) he interviewed other individuals who did not provide information on which Mr Cannane relied for the Chapter including Jan Eastgate; the Honourable Justice John Sackar QC, counsel for Mr Herron at the Royal Commission; Harold Sperling QC, counsel for Mr Herron in the *Hart v Herron* proceeding; Carmel Underwood, a former director of Scientology in Sydney; Dr John Sydney Smith, a neuro-psychiatrist who gave evidence at the Royal Commission and other civil proceedings in respect of Chelmsford patients (and in this proceeding); Mark Bunker, an American critic of Scientology; and Lisa Lloyd, a person who Mr Cannane understood was making a documentary about Chelmsford.

#### **4.5.3 Other evidence**

- 167 In cross-examination Mr Cannane insisted his end notes to the Chapter were a guide only and not intended to be comprehensive, it being the first time he had used end notes.
- 168 He said he cross-checked Mr Hart’s version of events with the Royal Commission report.
- 169 He rejected the idea that he had not included events favourable to the applicants. He said the applicants had obtained stays of criminal charges and disciplinary proceedings and he had not mentioned these facts but he was telling a certain story and did not think what he had done was

inappropriate. He agreed the story he was telling was about atrocities and horrors at Chelmsford saying:

Well, I went on what Justice Slattery said. And I think that those terms, atrocities and horrors, when you look at what happened – if you look at the deaths of 24 people from that hospital, the impact that it had on those families with the – who were related to those people who died, I think they were atrocities and horrors.

...

I'm not saying that I wasn't interested in any piece of information; what I'm saying is that I used Slattery J's report to tell the story of what went on there. Now, that was one part of my chapter, and I relied on him. And, I mean, he used terms like 'a catalogue of disaster' to describe what went at Chelmsford Hospital. And I feel like he is a trustworthy source .... the authority. ... on what went on there.

170 As to Mr Hart, he said:

My recollection of what's in the Royal Commission, is that it says that he was suffering from a pulmonary embolism, Deep Vein Thrombosis, double pneumonia and pleurisy. And I assumed that they got – I know that they did have access in the Royal Commission to both the Hornsby and the Chelmsford medical records, so I assumed that they came from there.

171 Mr Cannane explained that he did not speak to the applicants about the Chapter for numerous reasons:

- (1) the applicants' relevance to the story in the Chapter and Book was limited. Only one chapter dealt with Chelmsford. Dr Gill is only mentioned once in the book and Mr Herron on seven pages. Mr Cannane directed his attention to people with direct knowledge about the role of Scientologists in exposing the treatments administered to Chelmsford patients in the 1960s and 1970s or with contextual knowledge about Scientology;
- (2) he felt it was appropriate to rely on findings published in the Royal Commission report, as these findings "were by far the best available source for information about Chelmsford ... [and he] could see no evidence that those findings had been challenged by any of the doctors involved with Chelmsford ... since the Report was published." Mr Cannane said that he did not feel it was necessary to get responses from the applicants as he did not consider the Royal Commission findings to be allegations, but rather considered them "uncontested facts and conclusions that had been obtained after an exhaustive 21-month inquiry presided over by the eminent judge Justice Slattery";
- (3) he considered that had the applicants' version of events differed considerably from the findings of the Royal Commission report, this would have been apparent in the report

and related documents. Mr Cannane noted that the applicants “gave extensive evidence to the Royal Commission at which point they had the opportunity to put their version of events on the record”;

- (4) Mr Cannane did not consider the applicants to be reliable sources. He noted that “Justice Slattery made adverse credit findings about each of the Applicants ... including that they did not give reliable evidence while under oath .... [and] even if there had been a reason to talk to them twenty-five years later, I would have had zero confidence that they would tell the truth”;
- (5) Mr Cannane’s time was limited. He “spoke to over 200 people. While I was exhaustive in my research I also had to be judicious about who I spoke to otherwise I would never get the Book completed ... I believe it would have been a waste time talking to the Applicants”; and
- (6) Mr Cannane did not consider it necessary to put matters relating to Mr Herron’s treatment of Mr Hart to Mr Herron, as a jury had found Mr Herron guilty of assault and battery in that case.

172 Mr Cannane said:

...the focus of my book was scientology. The focus of my chapter was the scientology operation to expose what happened at Chelmsford. And then there was the section where I wrote, pretty much based on the findings, and I didn’t feel like I had to go to them [the applicants]. Because, as I said before, I felt like that was a fair report of a fair report, and they ... had legal representation at that inquiry, and I felt like they were dealt with fairly. And if I followed what Slattery J felt, I felt like that was good enough. And there was also another reason that I had; which was that I did not trust them to tell the truth. And if you look at Slattery J’s findings, there’s at least 10 or 12 times where he makes comments that they did not tell the truth or they lied under oath; both at the Royal Commission and, in the case of Mr Herron, during the *Hart v Herron* case. And I came to the conclusion that if they lie under oath ... what possibility is there that they will tell me the truth if I speak to them?

173 He said the position with Jan Eastgate was different as the allegations involving her had never been tested before.

#### **4.5.4 The imputations**

174 Mr Cannane intended to convey imputation A with respect to Mr Herron and was aware from conversations with Mr Hart, records provided to him by Mr Hart, the Hart Manuscript, and the interview Mr Hart gave on *60 Minutes* that:

- (1) prior to being admitted to Chelmsford Mr Hart was physically fit and operated a gym where he worked out regularly;
- (2) when he arrived at Chelmsford Mr Hart did not sign a consent form for ECT;
- (3) DST was not explained to Mr Hart at any time prior to it being administered to him;
- (4) Mr Hart was admitted to Chelmsford under the care of Mr Herron;
- (5) Mr Hart received DST for about 10 days and received ECT about six times while at Chelmsford under the care of Mr Herron;
- (6) when he woke up from this treatment Mr Hart was in agony and distress, vomited blood and was unable to move his limbs;
- (7) as a result of this treatment Mr Hart developed pneumonia, deep vein thrombosis, pleurisy, a pulmonary embolus and anoxic brain damage;
- (8) these conditions were serious and could be life threatening;
- (9) in his evidence to the Royal Commission Mr Herron agreed that a barbiturate dosage could be life threatening to a patient with any degree of physical vulnerability; and
- (10) a jury of 11 unanimously found that Mr Hart had been falsely imprisoned by Mr Herron and Chelmsford, and a majority of nine had found Mr Herron liable for negligence, assault and battery in the *Hart v Herron* proceeding.

175 Mr Cannane intended to convey imputation B with respect to Mr Herron in the sense that he intended to convey that the imputation was a finding of a jury in a civil case, and understood that all 11 jurors found Mr Herron and Chelmsford liable for falsely imprisoning Mr Hart, accepted Mr Hart had not consented to the treatment, and had not accepted the competing evidence of Mr Hart's admitting nurse.

176 Mr Cannane intended to convey imputation C with respect to Mr Herron, as he understood that Mr Hart had distressed breathing during DST and was vomiting or coughing up blood, and was in excruciating pain and felt paralysed, after waking from DST.

177 Mr Cannane intended to convey imputation D with respect to Mr Herron. He understood that:

- (1) the bottom part of Mr Hart's admission form, where the consent to ECT stamp was located, was removed at some point prior to the *Hart v Herron* proceedings;

- (2) Justice Slattery concluded that there was evidence to indicate Mr Herron was a party to a conversation in 1977 about photocopying Mr Hart's admission form to hide the fact that he had not consented to the treatment;
- (3) Justice Slattery concluded that many patients admitted to Chelmsford received various treatments without their consent;
- (4) Mr Hart did not sign the consent for ECT stamp on his admission sheet;
- (5) DST was not explained in detail to Mr Hart at any time prior to its administration to him, so he was unable to consent to that course of treatment;
- (6) Mr Herron should have known that Mr Hart had not consented to receiving ECT because the consent stamp on his admission form was not signed;
- (7) Mr Herron should have known that Mr Hart had not consented to receiving DST because Mr Herron had never explained it to him;
- (8) notwithstanding that, Mr Herron administered, and ordered the administration of, DST and ECT to Mr Hart; and
- (9) the evidence indicated that Mr Herron was involved in a conversation about how to conceal the fact that Mr Hart had not provided his consent to that treatment.

178 As to the conversation involving Mr Herron Mr Cannane said:

Well, I don't know why they were doing it, but certainly Slattery J believed that meeting happened. Marcia Fawdry said she was at that meeting and Slattery J made findings about that meeting as if it did exist.

...

...I don't consider it an allegation. I consider it something that Slattery J made a finding about. And in that section of my book I was relying on the findings of Slattery J to tell the story of what happened.

179 Mr Cannane only intended to convey imputation E with respect to Mr Herron to the extent that there was one trial that had deemed DST too dangerous. Mr Cannane's evidence is that "while that was only one trial [of DST at Parramatta Psychiatric Hospital discontinued in 1957] ... presumably that involved trials on more than one patient. Accordingly trials were conducted in relation to DST, and the treatment was deemed too dangerous ... I did not intend to convey that there was more than one trial in a general sense." He understood that:

- (1) other doctors avoided DST because they either had firsthand experience with the treatment and thought that it was dangerous, or had no experience with it but were aware of its dangers;

- (2) Dr Barclay gave evidence to the Royal Commission that when he was a medical officer at Parramatta Hospital in 1957, a trial of administering DST to patients was terminated because the doctors involved did not think it was terribly effective, thought it was too dangerous to go on with in that setting and the treatment scared the living daylights out of them;
- (3) Dr David Maddison, a psychiatrist who trained with Dr Bailey and became a Professor of Psychiatry at Sydney University, gave evidence at the inquest into Mr Carter's death in 1967 that he had tried DST but ceased using the treatment in 1956 because of the dangers;
- (4) doctors who did use a form of treatment that combined DST and ECT, including Dr Sargant, urged practising it with a level of caution and patient care that was not adhered to at Chelmsford;
- (5) Dr Sargant was of the view that:
  - (a) when administering DST, the Chelmsford doctors "put the patient much too deep";
  - (b) DST was never used widely in England, and when it was used it was of a shorter duration and produced a lesser depth of sleep than did the Chelmsford drug regime;
  - (c) English patients were more carefully selected and monitored by medical staff than Chelmsford patients; and
  - (d) continuous narcosis has remained the most problematic of all methods of physical treatment in psychiatry, as its results are the least predictable;
- (6) the Royal Commission did not find that DST as practised at Chelmsford could be said to have been practised in accordance with the methods regarded as proper by responsible psychiatrists in a "respectable minority"; and
- (7) Justice Slattery concluded that sleep therapy patients in England were put at far less risk than DST patients at Chelmsford.

180 Mr Cannane intended to convey imputation F with respect to Mr Herron. He was aware from reading the Royal Commission report that:

- (1) from in or about 1963 to 1979, DST was practised at Chelmsford, including by Dr Bailey, Mr Herron, Dr Gill and Dr Gardiner;



- (2) the Royal Commission concluded that there were at least 24 deaths of patients treated at Chelmsford that were caused by DST;
- (3) a substantial number of those 24 patients were in their 20s, 30s and 40s;
- (4) Justice Slattery concluded that:
  - (a) it is quite unbelievable that Mr Herron knew as little as he claimed about the deaths which were occurring at Chelmsford;
  - (b) Mr Herron knew the treatment was dangerous and likely to contribute to or cause a catastrophe;
  - (c) there could be no doubt that Mr Herron must have been aware that some patients were dying and their deaths were closely linked to DST;
  - (d) Mr Herron agreed in his evidence to the Royal Commission that by early 1974 he was fully aware that a number of patients had died during or immediately after DST; and
  - (e) Mr Herron knew that at least some DST patients had died while receiving the treatment but claimed in his evidence to the Royal Commission that he was prepared to accept explanations offered by Dr Bailey of the causes of each death, which were totally unrelated to DST;
- (5) notwithstanding the factors above, the doctors practising DST at Chelmsford, including Mr Herron, continued to give DST treatment to patients until in or about 1979; and
- (6) Mr Herron could not have been ignorant of the large number of deaths of young people at Chelmsford, which was a small, private hospital.

181 Mr Cannane gave this evidence:

You say that the four of [Dr Bailey, Mr Herron, Dr Gill and Dr Gardiner] are practicing this treatment?---Yes.

They knew it was dangerous and they continue to practice it?---Yes.

And they did so despite the death toll mounting before their eyes?---Yes.

You don't say, at any point, Dr Bailey's death toll?---No, I'm talking about the collective death toll at Chelmsford.

Right. So do you accept that here you intended to carry that each of those doctors, Bailey, Herron, Gill, and Gardiner were responsible for that death toll?---No. What I was conveying there – that a practice continued to take place at Chelmsford Hospital, that each of those four doctors participated in despite the death toll mounting. So what I'm talking about is broadly before their eyes in this small private hospital there's a mounting death toll and they haven't stopped practicing deep sleep therapy.

Well, the death toll being caused by each of them?---Collectively, yes.

Well, it's impossible, as you look at your book, for a reader to distinguish as to who was responsible for which deaths, isn't it. You don't distinguish it?---Well, I don't – I don't say how many patients from each doctor died.

...

Now, you say – you use the word 'cult' there, on page 179 [Chelmsford Hospital operated like a secretive cult]?---Yes.

I suggest to you, you were intending to carry that they were acting as one unit?---I'm not saying that ... there's more nuance to it than that, to say that they were acting as one unit.

And that you were accusing them as a group, of being responsible for what you describe later as 'atrocities'?--- ... What I would say is there's a collective responsibility in a hospital like that, in a small hospital, where things are going on that lead to the deaths of 24 people, to ask questions at the very least, about why this is continuing to happen. So I do think there is a collective responsibility about finding out what's going on and doing something about it.

182 Mr Cannane did not intend to convey imputation G with respect to Mr Herron. He intended to convey that death certificates were falsified at Chelmsford while Mr Herron worked there as a senior doctor. Specifically, Mr Cannane intended to convey that Dr Bailey falsified death certificates, which was a Royal Commission finding. Mr Cannane also believed that Mr Herron had falsified one death certificate. He gave this evidence:

And that statement of fact is that death certificates were falsified by the Chelmsford doctors, namely the four you have named on that page?---That's not what I'm saying. I'm saying death certificates were falsified at Chelmsford, but I'm not saying which doctors did it. And then later in the chapter, I say Harry Bailey did it.

Well, later in the chapter, you say Harry Bailey was found to have done it?---Yes. And if I meant to say that any of the other individual doctors did it, I would have named them as well.

You have named them on this page?---Not in relation to death certificates, I haven't. I've named them in the context of talking about how they ignored significant warnings from the medical profession and also the mounting death toll did not prevent them from continuing the treatment.

...

I want to suggest to you that the evidence you've just given about this is disingenuous and you know there's no other reading of that paragraph ... ?---I don't agree with you.

... you are telling the reader that these four doctors falsified their certificates?---I disagree.

183 Mr Cannane did not intend to convey imputation H with respect to Mr Herron, but intended to convey that during the period that Mr Herron was a senior doctor at Chelmsford, families of patients were lied to about how ill their family member was, and some families were not

allowed to visit patients while they underwent DST. This view was based on the Geason Manuscript, which quoted evidence given by witnesses to the Royal Commission and in police statements including Chelmsford patients and their family members; Justice Slattery's findings that Dr Bailey routinely provided death certificates for patients which were often false and avoided any coroner's inquest; that visitors were generally excluded during the DST program; and the Hart Manuscript, which stated that Mr Hart's sister had phoned Chelmsford and been told he was not allowed visitors. During cross-examination, this exchange occurred:

You're also telling the reader that these four doctors denied visitation rights to the families?---I'm not saying that and in fact, that is a finding of the Royal Commission and Slattery J does not name any individual doctors who did that. So I'm not saying that. I'm saying that that practice happened at Chelmsford Hospital.

...

And I'm suggesting to you that you intended to carry to the reader that my clients, with Gardiner and Bailey, regularly denied visitation rights and lied to family members?--- Well, that's not what I'm attempting to convey there.

And I'm suggesting to you that you know that's the only way to read that?---I don't think a reasonable reader would come to that conclusion and if they did, they've misinterpreted what I have written.

184 Mr Cannane intended to convey imputation I with respect to Mr Herron. He was aware of the report of Professor Alexander McFarlane who had assessed Mr Hart and confirmed that Mr Hart had been diagnosed with an organic brain injury and post-traumatic stress disorder. He also gave this evidence:

Well, Barry Hart told me it had caused him brain damage. Other doctors backed that up. Yes, Dr Snowdon had a different view. As I said, I wasn't really focusing on this section of the book but that's what Barry told me and other doctors like Dr Sydney Smith, for example, backed up Barry's version that he did have what they call an anoxic brain damage.

...

... I was relying on the views of two doctors who had given evidence in other cases for that verification.

185 Mr Cannane intended to convey imputation J with respect to Mr Herron in the sense that he intended to convey that Mr Herron was involved in the treatment of patients who died as a result of the treatment they received at Chelmsford and the treatment given by Mr Herron to those patients was grossly negligent, based on his reading of:

- (1) the Royal Commission report, including details of Mr Herron's administration of ECT to Peter Clarke less than half an hour prior to his death, and Audrey Francis's death at Chelmsford while admitted as Mr Herron's patient; and

- (2) the Geason Manuscript, including details of the Health Department's complaints of gross negligence and lack of concern for welfare against Mr Herron for his treatment of Miriam Podio and Audrey Francis, which Mr Cannane understood were stayed because they were out of time, rather than due to the merit of the claims.

186 Mr Cannane's evidence is that he "did not intend to convey that many of Dr Herron's patients died as a result of his gross negligence" but was aware of Mr Herron's "direct involvement in the treatment of two patients who died at Chelmsford ... [and] that [he] had provided treatment to other patients at Chelmsford who had died as a result of treatment they received."

187 Mr Cannane intended to convey imputation K with respect to Mr Herron. Mr Cannane understood that doctors at Chelmsford:

- (1) carried out a version of DST that was unsafe and not the way that other doctors, including Dr Sargant, recommended it be administered;
- (2) used unsafe levels of barbiturates on patients;
- (3) gave DST to patients who were suffering from alcohol withdrawal;
- (4) continued to give DST to patients after they became unwell; and
- (5) administered treatment to patients without their consent.

188 He said:

...you know, there's a view that DST, and certainly from Slattery J's findings, you know, it was dangerous, they shouldn't have been carried out in the way that it was, and that Dr Herron continued to engage in that practice.

189 Mr Cannane did not intend to convey imputation L with respect to Mr Herron. He intended to convey that records retrieved by Ms Nicholson from a rubbish bin showed that doctors at Chelmsford, during the period Mr Herron was a senior doctor at Chelmsford, were defrauding their patients' health funds. He knew there was a finding in the Royal Commission report to this effect and had not merely relied on the Geason Manuscript. He said he had cross-checked the reference in his end notes to the Geason Manuscript to the Royal Commission report's finding.

190 Mr Cannane intended to convey imputation M with respect to Mr Herron in the sense that he intended to convey that Mr Herron traumatised his patient Mr Hart by giving him DST without his consent. Mr Cannane also intended to convey that many patients were treated at Chelmsford without their consent while Mr Herron was a senior doctor there and that some patients were

traumatised as a result of their treatment; a view that was based on his reading of the Royal Commission report. Mr Cannane said that he did not intend to convey that many of Mr Herron's patients were traumatised by receiving DST authorised by Mr Herron without their consent. He explained:

Imputation M, you did intend to convey this?---In a qualified sense in that he traumatised Barry Hart. And so that was based on my conversations with Barry because he said he was traumatised. Certainly there was medical evidence that he had post-traumatic stress symptoms. So – and that was as a result of his treatment. So I don't agree with the term 'many' but what I do agree was I intended to convey that he traumatised Barry Hart by giving him DST without consent.

...

[I] want to suggest to you you did intend to convey 'many'....?---But not – not with Mr Herron. Many at Chelmsford. And there's a finding of Slattery Js where he says that many were given treatment without their consent. That's a direct finding of Slattery.

...

Because you didn't have a basis, did you, to say that ... Dr Herron had, 'Many patients who were traumatised and who hadn't given consent'?---No, I – I was referring to Barry Hart in that instance. I did not have evidence that he did the same to many patients.

191 Mr Cannane intended to convey imputation N with respect to Mr Herron in the sense that he intended to convey that the imputation was a finding of a jury in a civil case. He did not intend to convey that he had personally investigated the evidence and reached a conclusion that Mr Herron had assaulted and battered Mr Hart.

192 In respect of the imputations concerning Dr Gill, Mr Cannane did not intend to convey that Dr Gill was a psychiatrist. Mr Cannane was aware from his conversations with sources and the Royal Commission report that Dr Gill was a general practitioner who administered treatment to patients at Chelmsford in that capacity. In the Chapter, Dr Gill is referred to on one occasion as a doctor. No reference is made to him being a psychiatrist.

193 Mr Cannane intended to convey imputation E with respect to Dr Gill. In addition to the matters referred to with respect to imputation E and Mr Herron, he was aware from the Royal Commission report that:

- (1) in or around 1972, Dr Gill acquired an interest in Chelmsford;
- (2) from on or around this date until Chelmsford was sold in 1988, Dr Gill was effectively medical superintendent of Chelmsford;

- (3) despite the fact Dr Gill was anxious not to accept the proposition that he acted in the capacity of administrator, manager or chief executive officer of Chelmsford from July 1972 to 1988, the evidence was in favour of that proposition;
- (4) Dr Gill was not only a director and shareholder in Chelmsford but acted as a type of registrar; and
- (5) Dr Gill administered DST to patients at Chelmsford.

194 He gave this evidence:

It was really clear to me that Slattery J described him as a de facto superintendent of that hospital.

...

No, I didn't have to name him except he was one of the four doctors who did deep sleep therapy and he was a significant figure there.

...

And the reason you named him is because you wanted the reader to understand that he had engaged in all of the misconduct that you assert in the chapter?---No, I guess I was talking there a kind of about a collective responsibility for ... the four main doctors for ignoring the early warning signs and also continuing the practice and to allow that practice to continue. And I thought it was important to name him there because I was aware that he was, effectively, the superintendent of that hospital. And really, to be honest, if I'm talking about that it was probably remiss of me not to name him at that point.

195 Mr Cannane intended to convey imputation F with respect to Dr Gill. He was aware from the Royal Commission report that:

- (1) Dr Gill's treatment of his patient John Adams, including his direction that he be administered a heavy version of DST after which Mr Adams died, "amounted to an irresponsible experiment" and should be referred to the Director of Public Prosecutions for consideration of criminal and/or disciplinary proceedings;
- (2) Dr Gill was responsible for the death of his patient Miriam Podio, who died after receiving DST;
- (3) Dr Gill was involved in the treatment of Arnold St Clair while he underwent DST, and Mr St Clair died as a result of the treatment he received;
- (4) it was "unimaginable" that Dr Gill was ignorant of the deaths that were occurring at Chelmsford or of the fact that many of the deaths were linked with DST; and

- (5) Dr Gardiner had given evidence which Justice Slattery accepted that when deaths at Chelmsford were raised in the media, Dr Gill went through the pages of a death certificate book, discussing each death.

196 Mr Cannane was also aware from reading the Geason Manuscript that:

- (1) the Health Department lodged a complaint of professional misconduct against Dr Gill in respect of his treatment of Ms Podio, and that the proceeding was stayed because of the delay in lodging and prosecuting the complaint, rather than the merits of the case; and
- (2) concerns had been raised by Matron Smith, a doctor, and psychiatrists at Chelmsford about the use of DST.

197 Mr Cannane said he was aware of the death of John Adams when he wrote the Chapter but did not mention it.

198 Mr Cannane did not intend to convey imputation G with respect to Dr Gill. He intended to convey that death certificates were falsified at Chelmsford while Dr Gill was effectively superintendent of Chelmsford. Mr Cannane intended to convey that Dr Bailey falsified death certificates, which was a Royal Commission finding.

199 Mr Cannane did not intend to convey imputation H with respect to Dr Gill. He intended to convey that during the period that Dr Gill was effectively superintendent of Chelmsford there was a practice of lying to families of patients about how ill their family member was, and not allowing some families to visit patients while they underwent DST.

200 Mr Cannane did not intend to convey imputation J with respect to Dr Gill. He intended to convey that Dr Gill was one of four doctors involved in the treatment of patients who died as a result of the treatment they received at Chelmsford when it had been found in the Royal Commission report that Dr Gill was effectively the superintendent of the hospital from 1972. He explained:

...there was a mounting death toll that everybody in that hospital should have known about because it's a small private hospital and 24 people died there. In Dr Gill's time, it was at least nine or 10 people in a five-year period. So I'm saying that they continued to practice that therapy despite the warnings and despite a death toll. I'm not saying Dr Gill is a killer in that line. That is a complete misinterpretation.

201 Mr Cannane intended to convey imputation K with respect to Dr Gill to the extent it applied to his treatment of John Adams and that he was the medical superintendent of the hospital where

DST was conducted. He said that he understood the doctors at Chelmsford, while Dr Gill was the superintendent:

- (1) carried out a version of DST that was unsafe and not the way that other doctors, including Dr Sargant, recommended it be administered;
- (2) used unsafe levels of barbiturates on patients;
- (3) gave DST to patients who were suffering from alcohol withdrawal; and
- (4) continued to give DST to patients after they became unwell.

202 Mr Cannane did not intend to convey imputation L with respect to Dr Gill but intended to convey that records showed that doctors at Chelmsford were defrauding their patients' health funds but did not name Dr Gill as doing so. Dr Gill was medical superintendent of the hospital from 1972 as found by the Royal Commission including that it was probable that Dr Bailey had been charging for services which were not provided and continued to do so after 1972. Mr Cannane did not accept that the reference would be seen as including Dr Gill who had only been mentioned once in the Chapter.

203 Mr Cannane did not intend to convey imputation M with respect to Dr Gill but intended to convey that Dr Gill was one of a group of four doctors practising at Chelmsford where DST was given at times without consent. Mr Cannane was aware from the Royal Commission report that Justice Slattery found that many patients received various treatments without their consent; and that once patients were unconscious they were unable to consent and with DST doctors took on themselves the absolute authority to decide what should be done to patients, frequently without consulting them or their relatives. Mr Cannane also concluded from Mr Hart that receiving DST without consent was likely traumatic for a number of patients treated at Chelmsford. He gave this evidence:

... You have no basis at all to suggest, did you, that Dr Gill treated anyone without their consent?---No, I had no knowledge of that, and I had no intention to convey that.

#### **4.5.5 Discussion**

204 Contrary to the applicant's submissions I found Mr Cannane to be a frank, honest, open and credible witness. I do not accept the applicant's criticisms of his evidence or his credit.

205 The fact that there were some discrepancies in his evidence about the information he had available to him when writing the Chapter (which he corrected) does not mean that his evidence should be disbelieved. Far from his evidence being confused and inconsistent, he was



remarkably clear about the process involved in writing the Book. The fact that he made an error about having read Barry Hart's evidence to the Royal Commission when writing the Book is not a matter of serious concern. He corrected the error as he was required to do. The applicants' complaints about him delaying having done so do not suggest any lack of credit on Mr Cannane's part.

206 His explanations about his end notes were cogent and believable. He had never used them before. He did not cite every reference including not every reference to the report of the Royal Commission. Sometimes he cited only the first reference. He intended them to be a guide only and not to comprehensively identify every source on which he relied.

207 I accept the general effect of Mr Cannane's evidence. As the respondents submitted:

It is apparent from Mr Cannane's evidence in these proceedings that the Book was thoroughly researched and Mr Cannane had a good knowledge of both the content and the process he went through in writing it.

Mr Cannane was an honest witness. He made frank concessions during his cross-examination; for example he readily accepted that:

- (a) his endnotes could have been more detailed and included references to every single source for every assertion in the Book (Cannane XXN at T667.35);
- (b) he should have disclosed that Brian Bromberger, one of the authors of a book used as a source for the Book, had at one time acted as a solicitor for Mr Hart (Cannane XXN at T669);
- (c) he would have been able to find and contact the Applicants for comment prior to publication if he had wished to do so (Cannane XXN at T705);
- (d) he had made a mistake in his first affidavit in stating that he had read Mr Hart's Royal Commission transcript, which mistake he corrected (by affirming a further affidavit) when he realised he had made it (Cannane XXN at T714);
- (e) matters relating to Mr Hart's treatment at Chelmsford were not findings of the Royal Commission, but rather a recitation of the evidence of his treatment (Cannane XXN at T745);
- (f) certain sentences in the Book could have been drafted more precisely, particularly the sentence on page 179 of the Book relating to the competence of Mr Hart's solicitors (Cannane XXN at T794-5); and
- (g) there was one dissenting medical opinion about whether Mr Hart suffered brain damage as a result of his treatment at Chelmsford that he could have included in the Book (Cannane XXN at T836).

...

Mr Cannane was forthcoming and straightforward in his answers. He was willing to assist the Applicants' counsel, in some circumstances when such assistance was to his own detriment. He gave honest answers and it was clear he was telling the truth. To the extent that any attack is made on his credit, it should be rejected.

## **5. DST AND ECT AT CHELMSFORD**

208 The following summary is taken from the parties' submissions to the extent that I consider they are supported by the evidence. In this regard I should note that I reviewed numerous files of patients at Chelmsford. Clear patterns emerged throughout that review. The most important conclusion I reach is that I am unable to accept the applicants' proposition that the experts called by the respondents in any way misunderstood the essential aspects of DST and ECT as they were administered at Chelmsford. The various experts' understanding of DST and ECT as they were administered at Chelmsford, in all material respects, accorded with the overall effect of the evidence.

209 Nor do I accept the applicants' generalised proposition that because there were other sources of information with which the experts were not briefed, their evidence was unreliable. The submission remained at this general level. The applicants did not put any additional document to any expert suggesting that if the expert had known about that document they would have modified their opinion. The experts in question were briefed with the Chelmsford hospital files of various patients. This was a sound foundation for the conclusions they reached.

### **5.1 The doctors**

210 Dr Bailey was the principal proponent of DST at Chelmsford.

211 Mr Herron provided ECT to Dr Bailey's patients. He then prescribed DST to his own patients using the same procedures as Dr Bailey. Dr Gill treated six patients with DST using a modified version of some of the drugs involved but with the basic barbiturate components being the same. The DST patients were nursed in the same ward and were dosed by the nurses in accordance with a standardised treatment sheet which provided a dosage and time range for the basic drug components causing sedation.

### **5.2 The standard procedure**

212 The admission sheet was filled out by the receptionist, Ms Sansom, who would also seek that the patient sign a consent to ECT. There was no consent form for DST.

213 Patients were admitted by a nurse. They were not physically examined by a doctor on admission at Chelmsford. The nurse took the patient's history, weighed the patient, took other observations, organised nose and throat swabs, blood tests, liver function tests and urinalysis.

- 214 There was a standardised treatment sheet involving a cocktail of drugs to be used for DST. This treatment sheet was used for all patients irrespective of their age, weight or physical condition.
- 215 The components of the polypharmacy involved in DST changed over time but the main drug was the barbiturate Tuinal. The standard treatment sheet provided for Tuinal “200-400mg 4-6 hourly”.
- 216 The treatment sheet also generally included “Sod. Amytal 500mg IMI prn”. Sodium Amytal was another sedative, and “prn” was shorthand which meant that whether the patient received the drug was at the nurse’s discretion. On admission the patient was injected with sodium amytal in the general ward and then wheeled to the DST ward.
- 217 No doctor was on continuous duty (or on call). If necessary the nurses would call the treating doctor or Dr Gill who lived 10 to 20 minutes away.
- 218 As explained in greater detail below, I accept that the patients were in a drug induced comatose state. Dr Bailey and Mr Herron wanted the patients “asleep all the time”. While the practice of nurses as to drug administration differed to some extent (some always prescribed the maximum dose at the minimum time and others did not based on observations of the sedation level of the patient), the basic objective was for the patient to be unresponsive to light and sound for 24 hours a day. The indicators of the patients being comatose is that they generally tolerated tube feeding and were frequently incontinent in the sense that the usual method of toileting was for the patient to wet the bed. On some occasions patients were sufficiently conscious to be assisted to a commode, most probably when they were near the end of a dosage period. The drugs were also administered in a crushed form via the naso-gastric tube. As explained below I do not accept the evidence or submissions to the contrary.
- 219 There were generally around six patients in the DST ward. During the day shift, there was one registered nurse and a number of nurses’ aides or assistants responsible for the DST ward. During the night shift, there was one registered nurse responsible for the whole of the hospital, assisted by one or two nurse’s aides or assistants. They would sit in the doorway to the DST ward to be able to observe the patients.
- 220 Equipment in the DST ward included:
- (1) one or two sucker machines which were used for sucking out mucous from a patients’ airways;

- (2) one or perhaps two oxygen cylinders;
- (3) “Air Viva” bags which were described as a mask over the nose and mouth and a bag which the nurse would squeeze to ventilate a patient; and
- (4) guedel airways, intratracheal tubes laryngoscopes, bed blocks, torches, syringes.

221 As the respondents noted:

At one point, the hospital had a ‘Bird’s Respirator’, which was a machine that was capable of providing positive pressure ventilation to patients. But that was removed, because it could not be used by nurses, so was of little use in an emergency.

(Citations omitted).

## **6. EXPERT EVIDENCE**

### **6.1 Dr Richard Clark**

222 Dr Clark, an epidemiologist, considered the allegations in the defence that the overall mortality rate for DST patients was 17.1 deaths per 1000 admissions compared to an overall mortality rate for the general population of New South Wales at the time of 10.56 deaths per 1000 population. Dr Clark’s evidence compared the mortality rate of patients at Chelmsford undergoing DST with the mortality rates reported for psychiatric inpatients. In so doing Dr Clark assumed 24 deaths at Chelmsford in patients undergoing DST from a total of 1115 patients who were treated with DST for the period 1965 to 1979. Dr Clark used these calculations to support the conclusion that the mortality rates at Chelmsford were commensurate with those found in comparable jurisdictions for people diagnosed with serious mental illness and psychiatric patients.

223 There are two fundamental reasons why Dr Clark’s analysis cannot be accepted. For the purpose of his statistical analysis Dr Clark had to assume that 1115 patients were treated at Chelmsford over a year when, in fact (and as Dr Clark’s report discloses), this is the assumed number of patients treated with DST in total over the period 1965 to 1979. The average length of treatment of a DST patient at Chelmsford was something in the order of three weeks. Dr Clark conceded that using the actual data for Chelmsford would have made a substantial difference to his calculations. Dr Clark’s subsequent comparison with the results of a literature search depended upon the accuracy of his initial statistical analysis which cannot be accepted.

224 Further, the nature of the comparison which Dr Clark undertook is itself misconceived. The patients who died at Chelmsford died whilst undergoing or as a result of DST (see further below). They were treatment-related deaths. The deaths of the patients in the literature review

were from *all* causes including suicide. It is not apparent (and from the data reported seems highly unlikely) that the deaths of the patients reported in the literature were confined to deaths as a result of treatment. The reports appeared to involve longitudinal studies of deaths of psychiatric inpatients over time from all causes. Accordingly, the comparison is not meaningful. It is one thing to die from suicide, tobacco use, substance abuse or some other cause at some time, having once (or more than once) been a psychiatric inpatient. It is another thing altogether to die whilst actually undergoing or as a result of psychiatric inpatient treatment. A meaningful comparison might be the number of deaths at Chelmsford in patients undergoing DST (taken by Dr Clark to be 24 from 1115 patients treated with DST) compared to the number of deaths of inpatients at other psychiatric hospitals whilst they were undergoing the inpatient treatment. Dr Clark has not made that comparison.

225 The applicants relied on Dr Clark's report to support submissions of increased vulnerability to various morbidities in psychiatric patients. Again, the problem with this reliance on Dr Clark's evidence is that the literature reviews on which it is based concern deaths from all causes in psychiatric inpatients over time. Such increased risks over time cannot be compared to adverse events (including deaths) occurring whilst undergoing psychiatric inpatient treatment.

226 The respondents submitted that Dr Clark's report could be put to one side because it is of no assistance to the Court. For the reasons given above I agree.

## **6.2 Professor Ian Whyte**

227 Professor Whyte is a clinical pharmacologist and clinical toxicologist. Professor Whyte had prepared a report for the Royal Commission.

228 According to Professor Whyte barbiturates were introduced into medical practice in 1903 as sedative-hypnotics. By the early 1970s barbiturate overdose was a leading cause of drug-induced death and barbiturates were replaced by benzodiazepines.

229 Professor Whyte examined the dosage regimes used in DST at Chelmsford. He concluded that:

- (1) at the time there were no uniformly accepted indications for the drug regime used in DST at Chelmsford. The only acceptable use for the doses of barbiturates used was for the induction of a barbiturate-induced coma in the treatment of refractory intracranial hypertension in severe traumatic brain injury. This required very high level care in an intensive care unit and was associated with a significant risk of complications;

- (2) there was no evidence of any benefit from this drug regimen in any conditions (and consequently no accepted indication for the regimen), so that any adverse reaction and/or toxicity would be unacceptable. A simple risk-benefit assessment would indicate a very high risk of serious, potentially life-threatening adverse effects with minimal or no benefits;
- (3) given the absence of any benefit, there is no reasonable level of patient care and safety that could be achieved while administering the drug regime involved in DST at Chelmsford; and
- (4) if a very significant benefit justifying the hazards had been demonstrated in properly conducted scientific trials then the minimum care required would be 1:1 nursing care with frequent (hourly) observations of vital signs in a high dependency or intensive care environment with wall suction and oxygen by every bed and immediate access to anaesthesia or intensive care trained medical staff with facilities for full resuscitation, endotracheal tube intubation and ventilation.

230 In so concluding he noted that:

...a significant toxic dose of a barbiturate is 5 times the hypnotic dose (10 to 15 mg/kg or 500 mg) and severe toxicity may result from 10 times the hypnotic dose (20 to 30 mg/kg or 1,000 mg). The daily doses given during DST at the Chelmsford Private Hospital are similar to or very significantly exceed the doses associated with severe toxicity. The average adult, non-tolerant patient treated with this amount of barbiturate would be quite likely to be comatose with a significant risk of death. The additive effects of the other sedative drugs used would be expected to enhance the degree of coma and increase the risk of death.

231 As the respondents noted:

- (a) Patient Number 321 in Professor Whyte's report is Ronald Gamble. A section of his medical notes are in EXP00070A.[44]-54 (RTB4). The mean DDD [defined daily dose] of barbiturates with which Mr Gamble was treated was 25.33. That is equivalent to 2,533 mg/day. That was more than double the dose associated with severe toxicity and Professor Whyte's comments above in respect of the risk of death apply to an even greater extent.
- (b) Patient Number 862 is John Adams. The mean DDD of barbiturates with which Mr Adams was treated was 14.00. That is equivalent to 1,400 mg/day, which is about 40% more than the dose associated with severe toxicity. Professor Whyte's comments above in respect of the risk of death also apply to Mr Adams.

...

The treatment sheet used for Mr Gamble was the same as that used by Mr Herron for approximately 18 other patients of Mr Herron, including Audrey Francis, and two patients of Dr Gill, including one admission of John Adams.

(Citations omitted).

232 Professor Whyte said in evidence that he had done a literature review at the time he prepared his original report for the Royal Commission and could find nothing supporting the use of DST. He explained that pharmacologists routinely review literature to make recommendations about the use of drugs to treat particular conditions. As a pharmacologist he was qualified to “talk about the drugs, their effects on people, the way the drugs are affected by the person and the conditions they have”. He said from his literature review at the time of his original report:

The only – the only indication that I could find for which doses of barbiturates of the sorts that were being used in Chelmsford at that time was an attempt to induce barbiturate coma for the management of life-threatening head injury as a last resort, and the evidence there suggested that it was not beneficial.

233 He had seen no literature supporting the use of doses that matched those used in DST at Chelmsford for the treatment of mania, depression, schizophrenia, or alcoholism but had seen literature suggesting “less aggressive sedation”. Professor Whyte rejected the suggestion he was not qualified to give an opinion about indications for the drug regime, saying, he could review the literature to identify drug indications. He explained:

My expertise is in the drugs, the – and when you’re a pharmacologist the way you think about drugs is what are the drugs going to do, what are the effects of drugs, what are side effects of drugs, what are the adverse effects of drugs. And looking at the drug therapy with my understanding of drugs indicates that there is a high risk of adverse events associated with this drug therapy. It was of a such a level that the benefit would have to be enormous to make it worthwhile giving drugs at that – in those amounts with that risk associated.

Yes, and what I’m suggesting to you is you are not an expert ? --- – but I found no evidence that there was such benefit.

Yes, but I’m ? --- it would have been easy to find and easy to get published because it would have been such an impressive event.

234 It was again put to him that he did not have the expertise to give opinions about the benefit side of the analysis. He disagreed saying:

At the time I did the report it was about 10, 14 years, something like that, after the event. If there had been any significant benefit we would still be doing it at that time. And clearly it had stopped. Therefore it couldn’t have been of benefit, otherwise people would have kept on doing it. You don’t throw away a wonderfully useful therapy that is so good that it warrants doing it in spite of a list of nasty side effects that’s as long as your arm if it’s really that good. You don’t stop.

235 He was prepared to assume that there was literature from before the 1970s about the benefits of narcosis therapy but said that he could not find any literature reporting on the use of doses at the level used at Chelmsford for DST. He accepted there was no data available about the

efficacy of DST as used at Chelmsford but explained that as there was “a very high risk of serious potential life-threatening adverse effects” from the drug regimen used in DST at Chelmsford one did not need to be a psychiatrist to know that a justifying benefit would have to involve “saving people’s lives”. He further stated that if that is what they were doing at Chelmsford, then he would have expected the results to be published and for the treatment still to be used, but instead he found no evidence in the literature of any benefit from a drug regime of the kind used in DST at Chelmsford. As he put it:

...since there is no evidence of benefit, then – and there is clear evidence of harm, on the available literature and my knowledge, there is a disproportionate risk associated with it.

236 Professor Whyte said:

That’s the way medicine works. If you find a life-changing treatment that’s absolutely marvellous for a condition that otherwise doesn’t have any treatment or has ineffective treatment, you publish that information, other people replicate that information, it becomes part of standard medical practice. We’ve been doing that since we were doctors.

237 Professor Whyte said the death rate from barbiturate overdoses in the early 1970s was about six per thousand. He stated that the death rate he and Professor Henry had calculated for DST at Chelmsford during the Royal Commission in their Statistical Report and Analysis of Mortality in Chelmsford between 1963 and 1980 was around 17 per thousand or three times higher than people who tried to kill themselves using barbiturates. He explained that as part of the Royal Commission he and Professor Henry had been given the death certificates of people who had died who had received DST and calculated a mortality rate of 17 per thousand. He gave this evidence:

Did you find any literature which referred to the use of barbiturates in connection with – putting aside Chelmsford, did you find any literature which spoke of use of barbiturates in connection with narcosis or sleep therapy, putting aside Chelmsford obviously? --- In this report this is taken from the current drug information literature and I didn’t find any reference to deliberately induced narcosis as a treatment for a psychiatric illness. ... Sorry, unless you regard anxiety, for example ...as a psychiatric illness. In which case then an anxiolytic dose is an accepted indication for a barbiturate.

238 Professor Whyte accepted that there was a difference between taking barbiturates in one go and over time but explained that:

... it tells you that if you take somewhere between two to three grams of one of these barbiturates or more than that then you’re starting to get into a degree of sedation that is potentially associated with death. While that is different from taking it spread over time, you’re still getting the same amount of drug into you and if you’re starting to get substantially more than those amounts given over – even if given over a period of time,



you're also going to start to approach that level of toxicity.

239 I consider Professor Whyte's evidence rational and persuasive. I do not accept the applicants' criticisms of his evidence. The fact that Professor Whyte is not a psychiatrist is immaterial. The point of his evidence is that there was no reported clinical indication for the drug regime involved in DST at Chelmsford other than in severe head injury. As he said, he did not need to be a psychiatrist to know that the risk profile associated with the drug regime in DST at Chelmsford was so high that there would need to be a scientific study proving its capacity to save lives before that regime could reasonably be implemented. He found no evidence of any such study or any documented benefit as a result of his literature search. He did not concede that he had merely assumed no benefit. His assessment of the lack of any benefit that could possibly be worth the very high risk was based on his expertise in drug uses and his literature search. It does not matter that he undertook the literature search when preparing his report for the Royal Commission and could not now reconstruct its details. Faced with this evidence, the applicants' suggestion that the anecdotal reports from nurses and others that DST as practised at Chelmsford "worked" is of no value. Anecdotal evidence of that kind is not a substitute for the kind of study Professor Whyte said would be required to demonstrate the kind of life saving benefits that the drug regime would need to have had in order to justify its very high risk of serious adverse events including death.

240 The fact that Professor Whyte relied on information from his report to the Royal Commission is immaterial. That report was admitted into evidence and its contents are admissible for all purposes. The applicants' suggestion that the circumstances at Chelmsford where barbiturates were administered every four to six hours was far removed from ingestion of barbiturates in one go (which formed the basis for the analysis of potentially lethal doses) failed to have regard to Professor Whyte's evidence that even when given over time the amounts of barbiturates administered involved at Chelmsford approached or exceeded the potentially lethal dose. Contrary to the applicants' submissions, Professor Whyte's evidence indicated he undertook a literature review for his original report to the Royal Commission which was closer in time to the events in question and was unable to find any support for the drug regime as implemented at Chelmsford for DST for use in the treatment of psychiatric illnesses. This is sound evidence of a highly credentialed expert which is not in any way undermined by the applicants' reliance on unsubstantiated anecdotal evidence of patients for whom DST allegedly "worked". There is simply no credible scientific evidence that DST as practised at Chelmsford had any benefit for patients. Instead, the only credible scientific evidence is that of Professor Whyte of the absence

of any proven benefit for a regime which had a very high risk of serious, potentially life-threatening adverse effects.

241 Otherwise, in response to propositions of the applicants:

- (1) it is by no means “clear” that patients at Chelmsford undergoing DST never reached coma level 2. Based on the nursing notes which show that patients tolerated a nasogastric tube and were often incontinent it cannot be inferred that the patients were generally responsive to pain. It must also be inferred that one reason that DST patients were usually not given an anaesthetic for ECT was the apparent assumption that they were sufficiently sedated to be impervious to pain (although, on the evidence, this was clearly not always the case). Accordingly, it cannot be said that the patients were “maintained in a sub-coma state, either stuporous and at the end of each sedation period, drowsy”, nor that this “meant that the blood serum barbiturate concentration was never above 18 – being well below potential lethal levels for non-tolerant individuals”. This is directly at odds with Professor Whyte’s opinions and involves mere speculation and assertion;
- (2) Professor Whyte did not merely assume DST was ineffective. He based his opinion of lack of benefit on the lack of proof of benefit when such proof would be expected to exist if the treatment had in fact been effective. The applicants have not pointed to a single piece of scientifically credible evidence concerning the benefits of DST as practised at Chelmsford. Instead, they point to mere anecdote from the inventor of DST, Dr Bailey, whose self-interest in promoting DST is obvious, and anecdote from the applicants (whose self-interest is also manifest) and nurses (who were not in a position to assess the actual benefits, if any, of the treatment), as well as literature relating to forms of narcosis therapy different from DST (the trend of which clearly shows narcosis therapy becoming an outmoded therapy practised on the fringes of mainstream medicine by the 1960s and 1970s). The reported “success” rate of narcosis therapy in the literature is entirely unclear. The criteria used to determine “success” are also unstated;
- (3) the attempts to use Professor Whyte’s evidence to prove that Dr Sargant’s drug regime (which was different from that used at Chelmsford and had clearly stated different objectives of light sedation with patients capable of taking meals sitting up, going to the toilet and exercising) would have resulted in a greater level of sedation than Dr

Sargant reported is misconceived. It is not possible to go behind Dr Sargant's reports of either his stated aims or results. The inescapable fact is that it is obvious the aims of DST at Chelmsford and method used to achieve them bore no resemblance to the treatment Dr Sargant had reported. It is simply not credible to assert that there was no meaningful distinction between the two regimes;

- (4) the idea that Professor Whyte's evidence supported the notion that anything less than the potentially lethal dose does not involve an appreciable risk is entirely unfounded. His evidence was to the opposite effect. Any dose approaching the potentially lethal dose has a high risk. While it may be accepted that each person's tolerance may be different, there is nothing in the Chelmsford records to suggest that any consideration was given to individual patient tolerance. The drug regime was standardised with a "one size fits all" approach taken. The discretion to vary the drug regime built into the standardised treatment sheets was left entirely to nurses – in circumstances where the degree of risk meant that no safe level of care could be given to the patients undergoing DST; and
- (5) similarly, the idea that the discretion given to the nurses involved them safely titrating the dose of barbiturates for each patient is a fantasy. The evidence is that nurses had different approaches. Some liked the patients to be as deeply unconscious as possible and always gave the full dose at the minimum periods. Others might extend the period without a dose or give a lesser dose on occasion. They were doing so based on mere observation, not knowledge of the concentration of the barbiturate in any particular patient. And to repeat, they were doing this for a regime which had a very high risk of serious, potentially life-threatening adverse effects, and no safe level of patient care given its lack of scientifically proven benefit. The nurses were not to know what they were involved in as they did not have the expertise necessary to know. But their evidence that they gave the patients the best possible care (which no doubt they did within the confines of their role and the treatment regime) means nothing when the context is recognised that DST as practised at Chelmsford had a very high risk of serious, potentially life-threatening adverse effects, and no safe level of patient care given its lack of scientifically proven benefit. The applicants' submissions do not confront the evidence to this effect in any meaningful way. They rely on the nurses' evidence as if this could prove that DST was a safe and worthwhile treatment when the

nurses were in no position to know that they were involved in a dangerous unproven experimental treatment.

242 The applicants relied on a series of articles published between 1932 and 1974 to demonstrate the efficacy of DST. However, the applicants did not prove that any of the drug regimes used in those studies were the same as or equivalent to the drug regime used in DST at Chelmsford. It is apparent from the articles that the regimes involved varied widely including from the regime used in DST at Chelmsford. Further, a number of the articles point out the danger of narcosis as a form of therapy compared to other available therapies including ECT. Also, the studies reported on were of relatively limited groups of patients and thus their scientific validity is not immediately apparent. Moreover, the applicants called no expert evidence to analyse the studies in order to demonstrate their validity. They simply tendered the articles as if they spoke for themselves. None of the articles were put to Professor Whyte as in any way undermining the effect of his opinions. In these circumstances it is difficult to give any weight to the articles as proof of any fact, let alone the fact asserted by the applicants that DST as practised at Chelmsford had some benefit to the patients who underwent the treatment.

243 I do not accept the applicants' other criticisms of Professor Whyte's evidence. In particular, I reject this submission by the applicants:

Further, potentially lethal does not mean it will cause death, it means it might cause death and anything less than that does would not be regarded as an appreciable risk, Further, it is different for each person including because of tolerance: Whyte T1969.4-44.

244 The evidence was clear. Unlike other drugs the margins involved between sedation and death in the use of barbiturates are fine. The idea that the nurses at Chelmsford were (or were capable of) safely titrating the concentrations of barbiturates in the patients is fanciful. The idea that any dose of barbiturates which does not actually cause death involves no appreciable risk is simply bizarre. It may be accepted that different patients had different levels of tolerance for barbiturates but neither the doctors nor nurses had any valid method for determining the individual patient's tolerance. With the level of barbiturates being routinely administered as part of DST at Chelmsford the position was akin to an ongoing gamble with the lives of patients.

245 Based on Professor Whyte's evidence I am satisfied that the drug regime involved in the practice of DST at Chelmsford had a very high risk of serious, potentially life-threatening adverse effects, without any proven benefit. As such, any adverse reaction and/or toxicity

would be unacceptable and there was no reasonable level of patient care and safety that could be achieved while administering the drug regime involved in DST at Chelmsford.

### 6.3 Dr John Sydney Smith

246 Dr Smith is a psychiatrist who graduated in medicine in 1964 and qualified as a psychiatrist in 1969. He practised as a psychiatrist until about 1990 after which he ceased to be registered as a medical practitioner and undertook medico-legal consultancy work. Dr Smith provided a number of reports to the Royal Commission the contents of which he confirmed as evidence in this proceeding.

247 In respect of the death of Miriam Podio at Chelmsford whilst undergoing DST in 1977 Dr Smith said in a letter to the New South Wales Police Department Homicide Squad dated 22 February 1982 that:

...the use of prolonged narcosis was abandoned throughout the world in the late 1950's because it was found to be an ineffective but highly dangerous treatment and because the introduction of major and minor tranquilisers and antidepressant drugs allowed for the more appropriate treatment of patients with little risk of death or serious side effects.

248 He also noted that the mortality rate for prolonged narcosis therapies of between 1% and 5% made it some 10 times more dangerous than leucotomy procedures (0.3%) and 100 times more dangerous than a course of ECT (0.03%). He said that the use of prolonged narcosis continued in the 1960s at St Thomas' Hospital London under the supervision of Dr Sargant but there is no reference anywhere in the world of it being used after that decade. A 1972 paper by Dr Sargant's team (Walter CJS, Mitchell-Heggs N and Sargant W, "Modified Narcosis, ECT and Antidepressant Drugs: A Review of Technique and Immediate Outcome" Br J Psychiatry (1972) 120 at 651 ("**Modified Narcosis**")) indicated the precautions for treatment which should have been observed for Miriam Podio, including a full preliminary study of the patient, management in an intensive care ward, an aim of keeping the patient in a light state of narcosis where the patient was fairly easily aroused for meals and had no need for tube feeding, the patient had daily exercise, and was capable of walking to the toilet, the cessation of treatment at the first sign of any complication, and the administration of a muscle relaxant before ECT. He said the same requirements applied to patients Barry Hart and Coralie Walker. In none of the cases were these requirements met. In particular he noted that their "level of sedation was at times so deep that they were incontinent of urine and required feeding through a [tube]" and respiratory depression was evident in all three cases. The treatment involved them being heavily sedated 24 hours a day. No muscle relaxant was administered to Barry Hart or Miriam

Podio before ECT. No anaesthetic was administered to Barry Hart before ECT and anaesthetic was administered to Miriam Podio only seven out of the 11 times she was given ECT.

249 Dr Smith considered that Miriam Podio was an apparently healthy 26 year old woman who was admitted to Chelmsford and commenced DST on 28 July 1977. Her clinical notes indicate she was severely ill from the first day of treatment with evidence of a severe intestinal obstruction. She died on 12 August 1977. Dr Smith considered that her death was caused by the DST administered, the abdominal obstruction being the most likely precise cause of death.

250 Dr Smith considered that Coralie Walker had suffered a cardiorespiratory arrest with resultant brain damage as a direct result of the DST she received at Chelmsford.

251 Dr Smith noted that during the course of DST Barry Hart developed bilateral basal pneumonia and a deep vein thrombosis and was at times cyanosed. As a consequence, he suffered anoxic brain damage with cognitive changes and a personality change which were a direct result of the DST administered to Mr Hart at Chelmsford.

252 I do not accept the applicants' attacks against the impartiality of Dr Smith. The fact that Dr Smith gave evidence at the Royal Commission and continued to adhere to the conclusions he expressed at that time does not suggest any lack of impartiality. Nor does his expressed hope that others involved in the Royal Commission might also give evidence. Nor, for that matter, does the fact that he was an expert witness called by Mr Hart in his case against (then) Dr Herron. As he said, he attended court to give evidence about the treatment of Mr Hart. That fact did not (and does not) make him an advocate for Mr Hart. Dr Smith explained that from the time of the Mr Hart case against Dr Herron he believed Dr Herron and Dr Bailey were putting lives at risk with DST and wanted the matter investigated before other people got hurt. The fact that Dr Smith held (and holds) these opinions does not make him an advocate against the applicants. He was a psychiatrist at the time DST was being administered and was entitled to hold strong opinions, based on his expertise, about the risks of DST. Dr Smith agreed that he had assisted with two *60 Minutes* television shows about Chelmsford but, again, I do not consider that the fact that Dr Smith was a strong and public critic of DST means that he is incapable of or did other than giving impartial expert evidence in the present case.

253 Dr Smith explained that his report in this proceeding was based wholly on his previous reports to the Royal Commission and patient notes. He accepted that he was not an expert who could express opinions about the cause of death or about pharmacology. He was unaware that Dr

Sargant was still using narcosis therapy reported in a letter to the British Medical Journal in 1974. He agreed that he had not conducted a literature review for his report. He agreed he had interviewed Mr Hart for four and a half hours in relation to Mr Hart's case against Mr Herron. Dr Smith accepted that a CAT scan he arranged for Mr Hart to take showed no brain abnormality but said anoxic brain damage does not show up on a CAT scan; the same applied to EEGs. He agreed that a lack of information meant that he could not form a view as to whether Mr Hart was an appropriate candidate for DST. He agreed that he had no recollection of a report from Dr Snowden describing Mr Hart as "a resentful, disappointed middle-aged man dissatisfied with himself" but that it would have been relevant to the opinions he had formed about Mr Hart in this matter.

254 Dr Smith agreed that during the Royal Commission he had alleged that the Cerebral Surgery and Research Unit at Callan Park established by Dr Bailey had been funded by the CIA. He explained that he had taken over the directorship of this body and they remained unable to identify the funding for the establishment of the body and at the time the CIA was "funding mind experiments around the world, including in America, and it was suggested by various people that the CIA may have funded the Cerebral Surgery and Research Unit" which he mentioned in the Royal Commission. He agreed he had made at least six complaints about Dr Bailey to various bodies and was publicly critical of practices at Chelmsford during the early 1980s and had given evidence against Dr Bailey and the doctors involved in DST a number of times.

255 Dr Smith agreed that the mortality rate for narcosis therapy by the 1970s was on average 1% or less. He was taken to Dr Sargant's 1972 article, "Modified Narcosis" which stated at 656:

It must be stressed that the combined treatment of modified narcosis, ECT and antidepressant drugs has generally been reserved for those patients who have failed to respond to other methods of treatment, or less frequently, for those in whom subjective or objective distress made immediate relief of anguish desirable.

256 Dr Smith accepted this was a broader range of indications for treatment than he had indicated in his report.

257 As to Mr Hart, Dr Smith said that what was available in the notes indicated:

...that he had an adjustment reaction, that he didn't have a pervasive depressive illness or any other pervasive illness. He was reacting to the change in his appearance. But no evidence that he had a prolonged, intractable illness that hadn't responded to other treatments, including a course of ECT.

258 He accepted that the requirements he had identified in his report relating to the preliminary study of patients was not sourced from “Modified Narcosis” but from another article to which he had also referred: Clapp JS and Loomis EA “Continuous Sleep Treatment: Observations on the Use of Prolonged, Deep, Continuous Narcosis in Mental Disorders” Am J Psychiatry (1950) 106 (11) 821. He explained that Dr Sargant’s treatment was very different from that of Clapp and Loomis who were putting patients into an induced coma as was done at Chelmsford. When challenged about this Dr Smith said he based this view of DST at Chelmsford on:

...the amount of drugs that they were given, the fact that they were unresponsive, the fact that they could tolerate a nasogastric tube, the fact that they were incontinent of urine and often of faeces would indicate they were in a coma.

259 He drew these observations from the notes of the three patients he had reviewed.

260 He agreed that the papers which he had referenced did not require treatment in an intensive care ward but said that by 1972 it would have been imperative for any patient who was in a coma to be managed in an intensive care ward. He said intensive care wards had started to come into use in the 1950s. He stressed also that Dr Sargant was not treating people in a coma and so the regime of Dr Sargant could not be used as a reliable indicator for treatment as it occurred at Chelmsford which involved putting people into a coma. He rejected the suggestion that patients in a coma did not need to be catheterised as it was fundamental to know what fluid was going in and out. He agreed that for a patient sedated by barbiturates an anaesthetic before ECT was unnecessary but disagreed that a muscle relaxant was unnecessary due to the risk of fracture caused by the seizure induced by ECT. He had held the same view at the Royal Commission that it was a clear cut case that unmodified ECT should not be given under any circumstances but accepted that Professor Kiloh, an eminent psychiatrist, had given a contrary view at that time. Accordingly, he accepted that the matter was one of debate.

261 Dr Smith said that the most common complication of sleep therapy was bronchopneumonia so any temperature rise in a patient to the requisite degree would indicate pneumonia. As to Mr Hart’s symptoms as disclosed in the nursing notes Dr Smith said that with a “combination of high temperature like that and cyanosis and difficulty breathing – I don’t know that you could come to any diagnosis other than pneumonia”. Dr Smith did not accept that on his transfer to Hornsby Hospital Barry Hart was given only a provisional diagnosis of pneumonia and pulmonary embolus. Dr Smith considered pulmonary embolus consistent with the findings of Hornsby Hospital and:

...consistent with the last days that he was at Chelmsford Hospital on the 18th, where



his respiratory rate went up to 48, which is four times normal. And he had a high temperature and pulse. And, I think, 24 hours later it was still 52, so he was in extreme distress respiratory-wise. And that sudden distress would suggest something acute like a pulmonary embolus rather than just a progressive pneumonia.

262 Dr Smith continued:

And he was also, according to the Hornsby notes, that's when he started spitting up blood, which is a very big indication of a pulmonary embolus.

Well I want to suggest to you that each of those symptoms that you have just described are symptoms of pneumonia?---No.

Are you sure about that?---If it was pneumonia, you would expect it to get worse and his respiratory rate to continue up. Instead, it went up for 24 hours and then came back to 22 – so he was up about 40, 50 per minute for 24 hours, then he comes down to 22. You can't explain that on pneumonia, you would expect a progressive increase in distress, not a big spike in distress.

263 Dr Smith rejected the suggestion that written consent from a patient was not required at the time for both DST and ECT. He said:

The patients were put into a coma. Under the law at that stage anybody that lay under coma had to give informed consent, unless it was an emergency.

264 He reiterated:

I do believe it was mandatory under the law to get informed consent to put somebody in coma.

265 Dr Smith rejected the suggestion that he could not express a view about Mr Hart having anoxic brain damage. He gave this evidence:

So you can't, can you, express a view in relation to anoxic brain damage with cognitive changes and a personality change at this point in time, can you?---Yes, I can, because I saw the patient myself and that has been my indelible memory of what happened to Barry over these years.

Right. So you're repeating a view that you formed 40 years ago; is that right?---Yes.

But you can't tell us now the material that you relied upon 40 years ago to express that view?---I can tell you it was as a result of a four-hour interview and the results of investigations.

266 Dr Smith accepted that some rise in temperature was common during narcosis treatment but also gave this evidence:

And isn't it possible that some of the changes in temperature that we've seen in some of these patients are a reaction to the drugs that they're taking?---No.

You think that's impossible, do you?---I think that's extremely unlikely.

Why is that?---Because we know that infection is common in these people. We know that I think 40 per cent of Sergeant's [sic] patients got pneumonia. So I think by

extrapolation ... any rise of temperature, you have to consider to be pneumonia until proven otherwise.

267 Dr Smith also pointed out that two of Dr Sargent's deaths were from gangrene of the bowel and Dr Sargent had pointed out that paralytic ileus and haemorrhagic changes in the bowel are common in narcosis. In respect of the death of Miriam Podio, Dr Smith accepted he could not express a concluded view as to the cause of death but noted she had been vomiting up a dark substance which would be either faeces or blood. He noted the nurses said the vomit was foul smelling which would suggest it was faeces. He accepted the nurses did not say Ms Podio was vomiting up faeces but said "you have to explain what the dark, foul-smelling substance was" and he posited intestinal bleeding. He disagreed that low blood pressure was not a contraindication to ECT, saying it should have been treated as such. As to Ms Podio, Dr Smith said:

...she had the blood pressure falling, there was evidence of gross distension of the abdomen, some bowel sounds, aspiration and vomiting of dark fluid and melena [sic] stools, all of which would not be occurring in the normal person. So I attributed it to the treatment she was receiving at that time.

268 Dr Smith also gave this evidence relevant to Mr Hart:

Now, a pulmonary embolus is a life-threatening condition, isn't it?---It has got about a 30 per cent chance of dying if you have a pulmonary embolus. If you have bronchopneumonia on top of that, the ... increases. And if there is a - - -

Sorry?---If you have bronchopneumonia on top of that, the rate increases. And if there is a delay in getting on Heparin, it increases it further, so I would have thought his chances of dying were about 50 per cent.

Was he in danger of dying when he went to Hornsby?---Yes. He had a 50 per cent chance of dying.

269 As will be apparent from the above, I do not accept the applicants' criticisms of Dr Smith. Dr Smith was, and remains, a staunch critic of the use of DST at Chelmsford. That does not mean he was (or is) biased against the applicants. His opinions were based on his expertise. He readily made concessions, none of which undermined the substance of his opinion that DST was an outdated treatment at the time it was used at Chelmsford which placed patients at an unacceptable risk of death and serious complications.

270 I do not accept Dr Smith's opinion that Miriam Podio was vomiting either faeces or blood was an absurd opinion showing his "unrelenting bias" against DST and those who practised it. The nursing notes show Ms Podio vomited a dark and foul smelling substance. The proposition that this was either faeces or blood (given the patients were fed only Sustagen and juice via a nasogastric tube), accordingly, makes sense. Contrary to the applicants' submissions relying on the

opinion of Ms Fawdry (the former chief nurse at Chelmsford) it could not reasonably be inferred that this was the mere “coffee grounds” that were signs of bleeding from irritation from the naso-gastric tube. There is no suggestion in the evidence that these were foul smelling as in the case of Ms Podio. The fact that Ms Fawdry believed a nurse would recognise if a patient vomited faeces and that she had never witnessed it at Chelmsford may be accepted. But the fact remains, as Dr Smith put it, that the explanations for Ms Podio vomiting up a dark and foul smelling substance were those he gave – faeces or blood.

271 Nor do I accept that Dr Smith’s opinions were undermined by the fact that he was relying upon the nursing notes only rather than information in other records. The nursing notes provided a continuous narrative of observations of the patients. There is nothing to suggest that the other sources of information which were not available to Dr Smith conflicted with or undermined the veracity of the nurses’ observations. No such documents were put to Dr Smith. The applicants’ submission in this regard is mere speculation. None of those matters, in any event, undermined his fundamental opinion that DST was an outdated treatment at the time it was used at Chelmsford which placed patients at an unacceptable risk of death and serious complications.

272 I also do not accept that Dr Smith’s opinion that DST caused Ms Podio’s death was dependent on the assumption that Ms Podio had passed a melaena stool. The melaena stool was only one of a series of matters which Dr Smith said the nursing notes disclosed about Ms Podio’s deteriorating state. It is not apparent that he would have held any different view if Ms Podio had not passed a melaena stool.

273 I reject the applicants’ submission that “Dr Smith was not an independent expert and has been advocating in various forums against DST, Chelmsford and the doctors and nurses who practised at Chelmsford for over 40 years”. The consistency of his views against the practice of DST is not an indicator of bias. While Dr Smith accepted that he could not opine about the immediate cause of Ms Podio’s death he remained of the view that her death had been caused by DST. I consider Dr Smith’s opinions persuasive. As he said, all of Ms Podio’s symptoms emerged while she was undergoing DST. It is rational to infer that DST caused her symptoms (in the sense that it was a material contributory to her symptoms) and thus her death irrespective that the immediate cause of death might bear a more precise and different label.

274 I do not accept that Dr Smith’s opinions should be given no weight due to his alleged bias or because of the previous occasions on which he has given evidence including on behalf of Mr

Hart. Contrary to the applicants' submissions, Dr Smith was well placed to maintain the opinion he held that Mr Hart suffered anoxic brain damage as a result of DST based on his four and a half hour interview of Mr Hart. Dr Smith did not need to recall the substance of the interview in order to remain of the view that he has held for 40 years. Dr Smith's indelible memory of his diagnosis of Mr Hart's condition provided a sound foundation for the evidence he continued to give to the same effect. It is not the case that Dr Smith was giving evidence through a "prism of presumed misconduct" and "continued advocacy of Mr Hart's position". Nothing in Dr Smith's evidence suggested that he was doing other than giving truthful evidence of his medical opinions. The fact that Dr Smith has not been a medical practitioner since 1990 does not mean his opinions lack validity.

275 I reject outright the applicants' unfounded assertions that Dr Smith "lied" when he said he was not part of Mr Hart's legal team and had worked on the case for weeks rather than months. I accept Dr Smith's evidence that his role in Mr Hart's proceeding was to give independent expert opinions and advice. The fact that he did not recall the length of time the preparation for the case had taken does not support the assertion that he lied in his evidence. I did not find anything about Dr Smith's evidence "remarkable and discreditable". Dr Smith rejected the assertion that he could not give impartial evidence in this case given his previous involvement with DST and Chelmsford but there was nothing "remarkable and discreditable" in him so doing. Once it is accepted (as I consider it must be) that Dr Smith's opinions for the past 40 years have been based on his expertise then the notion that he must be biased against the applicants because of the many complaints he made and actions he took to expose DST as practised at Chelmsford falls away. His strong views against DST and the actions he took are a result of his medical expertise. Consistency and strength of view does not mean bias or partiality. The fact that Dr Smith "gave interviews about Dr Bailey, made many complaints about him, gave evidence against him in a number of matters, gave interviews for books and was accused by Dr Bailey in his suicide note" does not mean that it is absurd to accept Dr Smith's impartiality. The applicants wrongly assume that Dr Smith was not properly relying on his medical expertise in taking all the steps he did and in giving evidence in this proceeding.

276 Dr Smith's evidence that DST was an outdated treatment at the time it was used at Chelmsford which placed patients at an unacceptable risk of death and serious complications is persuasive and I accept it. Otherwise, I infer that Dr Smith's evidence about ECT without an anaesthetic assumed that the patient was sedated to the point of not feeling pain (which, on the evidence, was not the case for all DST patients at Chelmsford). Further, on the evidence in this case,

Professor Kiloh seems to be in a minority of one in terms of independent experts considering ECT on DST patients without a muscle relaxant was acceptable.

#### **6.4 Professor Gordon Parker**

277 Professor Parker qualified as a psychiatrist in 1973. He provided a report to the Royal Commission which considered numerous patient files and gave comments in light of what he considered to be acceptable standards or practice during the years of treatment. His essential conclusion was that DST as practised at Chelmsford was not acceptable at the time. According to Professor Parker DST has never been established empirically as a valid treatment for specific psychiatric conditions or as a non-specific modality having benefit across a range of psychiatric conditions. He also identified various unacceptable practices from the Chelmsford nursing notes. He said further that if a serious or catastrophic side effect occurs in a medical setting then an investigation should be initiated. The death of one patient alone at Chelmsford while under DST should have led to an immediate investigation. If a second gravid incident occurred the procedure should have been suspended or ceased until the causes had been identified and corrective strategies introduced if the procedure were to be continued. However, DST continued at Chelmsford after several patients had died which was unacceptable clinical practice.

278 Professor Parker considered the history of sleep therapy could be summarised quickly as there were few practitioners involved in it. Professor Parker considered Dr Sargant:

...a very – a very controversial figure. A very polarising figure. A very dominant man, in many ways, in British psychiatry. A zealot who clearly wished to find breakthrough therapies. Prior to being a psychiatrist he had engaged in a project to treat pernicious anaemia and given large amounts of iron and created major problems for the patients. As a consequence he had a nervous breakdown and was admitted to a psychiatric hospital into a – into a mental hospital with severe depression. A fairly extraordinary issue to occur for a senior psychiatrist – for a senior doctor. As a psychiatrist he was seen as important by some people, but the majority of commentators around the time saw him as cruel and irresponsible. He certainly set up a sleep therapy ward, but it does not really correspond very much to the Chelmsford strategies. For example, he required that the nurses monitor each patient every 15 minutes, and also, the patients were woken for at least six hours each day to be fed, to be washed and to be toileted, and even then, with those sort of safeguards in place, the death rate was apparently quite distinctive, as it had been with all the previous practitioners who had introduced sleep therapy, but Sargant never gave any data that I'm aware of in terms of the actual death rate. In addition, the medications that he prescribed during sleep therapy were seemingly quite different to those given at Chelmsford. So while he gave medications to induce sleep, most of the adjunctive medications were antidepressants, because most of the people that he was going to be treating were those with a depressive disorder. So the – and there's no doubt that Bailey was influenced by Sargant, but the way in which DST was implement at Chelmsford doesn't correspond strongly at all with

Sargant.

279 Professor Parker accepted that the source of his information that Sargant required 15 minute checks by nurses was a Wikipedia article and Dr Sargant's own papers did not mention any such requirement but noted that the papers were not dealing in detail with nursing practices. He acknowledged he was not familiar with various articles between 1937 and 1970 concerning narcosis therapy (being those on which the applicants relied for their efficacy argument, which I reject). Professor Parker said he had not assumed that the matters alleged in the statement of claim were true in providing his opinions as he had not read it.

280 He confirmed his opinion about unacceptable practices at Chelmsford in these words:

Firstly, as I state there, in any medical setting, if there's a catastrophic event such as a patient dying you would expect that the hospital would take that very seriously ... exactly what had occurred. These days there's a process called root cause analysis. In those days there wouldn't have been necessarily such a formal process, but in any hospital that practised to an acceptable standard, they would say, 'Why did this occur? Were there any reasons that need to be considered and addressed or re-addressed?' If a second death occurred, that would be an even more profound signal to say, 'We've got a major problem and something needs to be done.' If a third death occurred, then I would have thought any hospital that practised with any basic acceptable standard would immediately abort the procedure, notify the appropriate authorities, which in that instance would be the Health Department, and wait for a close investigation. What I interpreted as occurring at Chelmsford was that the process went on and on and on with more people dying, with no notification by the hospital to the Health Authorities with – with internal processes unclear. I understand that there was one meeting, at least, of the medical staff, where some concern was expressed and this was brushed aside. So it seemed to me that the multiple deaths created something that we've never had previously in Australia. Calamitous and catastrophic. And I think on – even on international standards, I cannot imagine in any western country where if patient deaths kept on occurring there would not be an immediate cessation of procedures and investigations to work out what was going on and why people were dying. So that's the background for my broad comment there.

281 He continued:

I mean, even if it was three patients, it seems to me my – my comment there applies. If it was 24, that's extraordinary.

282 He accepted that he was assuming that DST had caused the deaths.

283 Professor Parker said:

But to give one example, in the files that I was provided with, there is a typewritten treatment template that is, I think, in all of those files where there is a list of prescribed medications, multiple medications with the typed name of Dr Herron underneath. And they are, usually, in those files unsigned and undated. So it would appear from the patients' records that I reviewed, these patients were admitted to a hospital and this template was applied in a procrustean manner. No respect for the age or the weight of the patient, whether they had any physical conditions. Herron had a typed document

for treatment that was given to everybody in a standardised way without any individual respect. In the files, there is no documentation, in general, by Dr Herron, on the admission of the patient. There is the occasional reference in the progress notes when the patient gets into an emergency. So if I was to judge his clinical care, which is your question, I would regard that as absolutely unacceptable clinical care and competence. That is, I cannot think of any other acceptable doctor strategy – sorry, I’ve just got to get it right – I cannot think of any circumstance where complicated, detailed and potentially dangerous procedure requiring multiple medications would be provided in such a formulaic way that it would just be put into a patient’s file, presumably by notices about all medications these people were to receive and not to have that signed by a doctor and dated. That is absolutely unacceptable clinical practice at those three levels. (1) Firstly, the formulaic approach. (2) Secondly, not to have it signed. (3) And thirdly, not to have it dated.

284 Professor Parker did not accept that if he had not been given all the medical records his opinion would necessarily change. He continued:

So I would expect that there would be a referral letter. Why is this patient being admitted, at this particular time? A minor issue, but salient. Of greater importance, I demand in any appropriate hospital, that there would be a history written and written by a doctor, with a doctor recording the diagnosis, recording any salient medical conditions which might – or allergies, which might be highly relevant for the treatment that is about to be given, that there would be a physical examination to ensure that the procedure would be safe, that there would be relevant pathology tests undertaken if there were any problems and that all of these would be signed and dated. I can’t find that in any of the files. If it exists, well, I have never seen it. As noted there, I would expect that the treatment would be calibrated for the individual patient respecting their age, their physical condition. Instead of that, what we see is this template unsigned, undated by Dr Herron, applied in this procrustean manner. I would expect that all subsequent treatments would be recorded by the doctor and signed and dated. Now, it’s true that sometimes, late at night, or a weekend, a nurse might ring a doctor and say, ‘We’ve got this problem.’ And a doctor might order a medication. But then, in those times, as of now, if it wasn’t signed at that time, the doctor would be obliged to actually sign off in prescribing that medication in the next day or so. I see no record of that, at all. I virtually – I can’t think of seeing any significant progress notes by the medical staff. And I think that’s, again, unacceptable clinical practice. There are no medical comments or annotations about how the sleep therapy was progressing. The only comments are by nurses and then, they’re generally, reporting the extent to which the patient was asleep or more commonly reporting the degree of distress. So again, that’s a major concern, that there is no medical staff reports. When the patient developed an infection or some other medical complication, I would expect that there would be an examination by a medical practitioner and have those details recorded. That is very, very, rare. Nearly always, it’s a nursing annotation about a fever or incontinence or whatever. And then, I would expect that there would be some final stages report or discharge summary. So there a whole series of standard procedures that have been in place for a long period of time where medical practitioners are required to do a whole series of things when a patient is admitted to a hospital and managed through their stay. And coming back to your question about Dr Herron’s clinical competence and sophistication, then, if he was responsible for those patients and on the documentation that I was provided with, and I think, that fails at so many levels.

285 He said his experience of hospitals was “pretty broad” as he had worked in large teaching hospitals and private hospitals and he said he was also “the first [psychiatrist] surveyor for the

Australian Council of Healthcare Standards which meant that I spent a number of years going around, looking at a number of public and later, private hospitals. So I think, I have seen the public system quite extensively and the private to a reasonable degree.” He accepted he was not working in private hospitals in the 1960s and 1970s. He did not accept, however, that psychiatry was an “evidence free zone” in the 1960s and 1970s. He rejected a simple cost-benefit analysis for DST, saying:

But for psychiatric treatments that could cause acute death, I doubt whether anyone would simply apply a cost benefit equation. And if we look at the history of deep sleep therapy, the major practitioners, there was a significant death rate in all of their accrued patient lists. And I think the main reason was that the – the common drug used to prescribe, or to put people to sleep, was a combination of two barbiturates, and that combination had a very narrow band between the drug being effective in terms of putting one to sleep and actually killing you. So that all the three or four key practitioners of deep sleep therapy had a significant death rate in terms of applying the treatment. Now, if we consider other treatments that were available at the time, like ECT, you don’t see death rates associated with ECT. You don’t see it with antidepressant drugs by and large. So the imbalance in terms of the potential risk rate, the high risk of death rate with DST goes way beyond any other treatment available now and in the 60s or 70s.

...

What I’m saying is that in the early studies by practitioners, even with small numbers, there is a figure exceeding 10 per cent. We don’t know the figure for Cameron and we don’t know the figure for Sargent. But again, I go back to a point that I made in my report in September 2019: the death of a single patient in any medical procedure or any psychiatric procedure is a calamitous event requiring action and redressing to find out the factors. So whether it’s one in 100 or one in 1000, it’s still significant. If, as it was for Chelmsford, there were 24 patients as a minimum, that, to my mind, is calamitous.

286 Professor Parker rejected the proposition that an outpatient assessment by a doctor negated the need for a physical examination on admission to hospital, saying:

Well, it depends when that examination took place, doesn’t it?---No, it doesn’t. It doesn’t. Even if a person was transferred at 1 o’clock in the afternoon and being seen by a doctor at 9 o’clock in the morning, it would not negate the need to have an adequate history but, more importantly, physical investigation, annotation of other comorbid conditions that could create problems for treatment. All of those would need to be recorded in the hospital file on admission and they’re certainly not negated by the outpatient evaluation that preceded it, if it occurred.

Well, I want to suggest to you that triage nurses around the country conduct these sort of examinations on admission to hospitals?---They are triaging; they are not doing the medical evaluation or treatment. They’re triaging.

Yes, and it’s within the realm of a nurse to carry out the investigations that you see here?---These investigations are limited. They are not recording the medical history, the side effects and so on and so forth. But as I say, no patient gets admitted to a hospital without being seen by a doctor. The triage process is simply to prioritise which patients need to be seen immediately, those that need to be seen urgently and those that can be seen at leisure.



...

Patients are admitted to private hospitals without seeing a doctor upon admission?--- Well, I'm not aware of that, and if it is occurring, then it would come under my same, you know, suggestion and conclusions about inappropriate treatment. I know of no hospital in Australia that has a policy of saying, 'We can admit without a medical evaluation.'

What if this patient had literally just come from Dr Bailey's rooms?---Even so, it still stands that when a patient is admitted to a hospital, there needs to be a history recorded – and I went through some of the issues before – a referral note – I mean, where is the referral note from Dr Bailey? Secondly, a diagnosis. Thirdly, the admitting staff would need to record the history and do the appropriate physical investigation, order your appropriate tests that might need to be done, and I think I've detailed the other nuances.

287 He rejected the notion that Dr Bailey was in a better position to know what reporting was required in a private hospital given he had been practicing since 1963, saying:

... I think that I would more conclude that he was cavalier in terms of ignoring the general requirements. And as I say, there seems to be a whole stream of issues of omission and inappropriate procedures in terms of these patients being hospitalised leading right through to patients developing serious complications and then eventually dying. And the process probably begins right here. And if your assumption is that because he had been practising for a fair amount of time that he was competent, sophisticated and applying appropriate procedures, I don't accept that assumption.

288 Professor Parker rejected as immaterial the idea that there was no legal obligation to do what he was saying was required. He said:

You know, training from your medical student days inculcate a certain set of procedures as being required. I've already mentioned that I was a trainee at Callan Park Hospital in the late 70s and early 80s. And all of those things that I have gone through were regarded as our tasks for admitting a patient. If you say, 'Was there any legislative requirement to do that?' Of course not. Is it standard medical practice? Yes. And it has been for a long period of time.

289 He rejected the idea that a failure of record keeping did not involve a failure of care, saying:

No, the admission – recorded admission history and progress notes are a communication record for all staff be informed about what is actually going on. So it's not a strategy designed to avert, you know, some later legal claim as its primary motive. It's for the communication of the staff.

290 This exchange then occurred:

Right. But in this case, where Dr Bailey is the treating doctor and there are not other doctors who from day – as a matter of course, treating his patients, he doesn't need to have in the hospital records every single thing that he's thinking and doing because he knows what he's thinking and doing?---I accept that to some degree, but I do not accept it that it holds for the issues that I've mentioned two or three times. Dr Bailey has not informed in this record why this man needed an ambulance to bring him to the hospital. Not informed us about comorbid conditions ... us about how he came to the diagnoses. That's unacceptable, in my view. Even if he – if you put the argument that he's a singleton practitioner, those things need to be documented so that staff can ask

questions. In a healthy unit, I would expect, even if I was the most senior psychiatrist, that with a comprehensive record, a nurse might come to me and say, you know, 'Dr Parker, did you consider X, Y or Z?' That's why we need documentation. You cannot – you know, no man is an island. Similarly, in a hospital in particular, you cannot act as a singleton unless you're running a very risky ... of course, believing that you know everything and no one else needs to know anything at all.

291 Professor Parker gave this evidence about consent to DST:

Why is that not a consent?---Because consent requires filing out – sorry, signing a form.

No it doesn't. Not for deep sedation?---For any physical procedure, a consent form, I would expect, would be needed to be completed.

But in the 1970s, there was no requirement that there be a written consent for sedation?---That may be so. But if you had an anaesthetic you would have to sign a consent form. The level of sedation these people were given was at the anaesthetic level.

But you're not aware of any written requirement?---No. I'm not. But I would have, I mean, I imagine that the hospital would have sought a ruling on that as to whether, in fact, when they admitted people for sedation, whether, in fact, they did need a consent form. I would imagine there would need to be one.

Well, it would be quite unusual, wouldn't it, for there to be a requirement that something be written down and to not have that requirement, itself, written down?---Well, if you're accepting a procedure where you could die or you could get serious side effects, you would also expect that there would be a consent form that you would sign which is allowing you or informing the hospital that you've been made aware of the risks and you are accepting the risks and having the procedure.

And that's what's required now?---And in any good hospital, would have been required for many a period. But I, obviously, can't be explicit about whether it was formalised at Chelmsford or not.

...

I still remember, as a junior doctor, in the mid-60s, any procedure that we did, we needed people to sign a consent form.

292 Professor Parker returned to the standardised nature of the DST treatment at Chelmsford saying:

And you would, certainly, never expect that the same template in terms of the number of drugs and the doses of the drugs would be applicable to all patients. People with liver disease, all sorts of other problems, would require quite differing doses of barbiturates. People in terms of their age and gender would benefit from differing doses of the antipsychotics and other medications. The assumption that everybody should receive the same lengthy list that, what I have referred to as polypharmacy at the same doses as having universal relevance is, to my mind, absolutely inappropriate.

Well, they're not the same, are they, when you actually look at them?---There's quite a bit of movement within the doses, isn't there? I haven't found it.

Well, if you look at Tuinal, it says: *Four to six ... hourly.*?---No. I'm – talking about from patient X to patient Y to patient Z.

Yes. But ?---This is a template in so many people's files where the name 'Bailey' and 'Herron' is on the bottom, it's been printed out beforehand and it has not been tweaked or modified to respect the nuances of the particular individual patient.

So it's not for this, but are you saying you've never seen any that are hand amended?--I can't remember seeing any, no.

So just looking at the drug regime itself?---Yes.

Can you see that there's actually range within the actual regime itself?---Yes. Yes.

And that, for example, for this one, the Tuinal is four to six ... hourly?---Yes.

And with the Neulactil, were – did you understand how that drug worked?---Well, it's an antipsychotic. But the barbiturates and here, specifically, the Tuinal, as I said earlier today – the dose when they become effective was also pretty close to the dose of lethality and high risk. So how, when you give a template like this, are you expecting the nurses to operate? Do they start at the minimal dose? Do they just pick a figure that strikes them as a good estimate for the day? There is no, that is not the way to proceed and it has never been an appropriate way to proceed, in medicine.

So you weren't given any instructions, at all, at to the method by which the nurses at Chelmsford administered these drugs?---No.

So you weren't told, were you, what the nurses looked out for and what – and?---I'm not seeing, no. If there was a document saying that, you know, Tuinal should be started at a certain dose and the patient observed and monitored and then the dose could be increased subject to ABC which is, which would be an appropriate document. If that exist[s], I haven't seen it.

Well, putting aside whether there's a document or not, you had no instructions, did you, as to what the nurses looked out for, for each individual patient, before administering the barbiturates?---No.

So for example, if a patient was at the four hourly mark, asleep, the nurses, you were not asked to assume, were you, that the nurses would sometimes not give the barbiturate dose for that four hourly mark and that four hourly mark?---In some of the histories I went through, there were reports by the nurses of patients being extremely distressed, breathing heavily, seemingly, in nightmares, and where seemingly, the nurse seemed to give the dose that was written in the schedule rather than saying or ringing the doctors and saying, 'Look, I think, we've got a situation of concern here. Should I give the medication or should I not?'

...

Right. And I want to suggest to you that you've assumed, in expressing your views about the fact that this treatment sheet was applied apparently without regard to any physical or other features of the patient, you've assumed, have you, that the nurses did not take steps themselves to monitor a patient's condition and make an assessment of the patient before administering any of these drugs?---I haven't made any single assumption, but if I was to speculate now, I suspect there were some very good nurses who knew exactly what to do: lighten the dose, increase the dose. There would have been others – untrained, naïve, whatever – who would have just followed the formula. And others where the mix would have been excessive. We have to consider why so many people died, and the answer to that lies very much, in my mind, from this formulaic approach to things, where it would have been beyond the capacity of nurses to make fine judgments about – with a mix as big as this – which drug to tweak, which drug to lower, which drug to increase. Even a skilled anaesthetist involved in keeping

people asleep would never have as many medications as this, would never try to mix and match the whole lot, and would have great difficulty in making a judgment as to whether to lighten the patient or to sedate them further. To expect that of nurses is to absolutely increase the probability of terrible consequences.

I want to suggest to you, Professor, that you've underestimated the nurses that were working at Chelmsford Private Hospital?---Then why did so many people die?

Well, with respect to that, Professor, you don't know what the cause of death was, do you? That's not something that was part of your instructions?---From the files, it seemed that a high percentage developed pneumonia and fever and other significant medical problems which were not appropriately handled. One would have expected that if somebody had developed something like that, they would have been either treated within the hospital or, more likely, transferred to a general hospital in a state of urgency and emergency and their lives would have been saved. It would appear that that did not occur. They stayed at Chelmsford and many of them died.

...

Well, no, Professor, because I'm trying to understand what assumptions you've made in expressing the views that you're expressing, and you're telling me about patients who are so sick they need to be transferred to a general hospital, and what I'm saying to you is that no such patient was within – or was provided to you by way of example, and I'm wondering from where you get that factual material?---I'm getting it, as I say, from the treatment sheet, where I say so many medications of different classes of medication – barbiturates, antipsychotics, so on and so forth – you will need an extraordinary cocktail where the capacity of a skilled anaesthetist or intensive care specialist to know how to manage the doses when somebody was starting to get into trouble, be it a fever or some other medical complication – you know, bowels failing to work, so on and so forth. Even a skilled doctor within those specialities would have great difficulties. Expecting nurses to handle that situation within the hospital itself when doctors were not recording that medical problems are going on, by and large, and not – when somebody was ... attending just to audit, say broad-spectrum antibiotics and so on, strikes me as a considerable concern.

293 After being questioned at length about the appropriateness of responses by Chelmsford to symptoms in individual patients, Professor Parker repeated:

I think we have to look at what is the basic issue of concern. The basic [issue] of concern is at least 24 people died. And that is an extraordinary event. And that deaths occurred for an extended period of time without those deaths being seemingly notified. And if we – you looked at some of the international literature yesterday. Even if we accept the international literature that deep sleep therapy was applied for a period of time, the mortality rate at Chelmsford would seem to be extraordinarily high. This should have been a red alert by the hospital to determine what was going on. If the hospital and its management didn't make those inquiries, the Department of Health wasn't called in and didn't investigate, it seems to me that, irrespective of the time internal, it's still important to work out what went wrong and who was responsible and all the contributing factors.

294 Professor Parker accepted that he had read parts of the Royal Commission report and assumed that its findings were correct.

- 295 Professor Parker said that he graduated in medicine in 1967 and was a junior resident medical officer at Parramatta District Hospital from 1967 to 1968 where he was required to contribute to patients' medical records. From 1968 to 1969 he was a senior resident medical officer at the Prince Henry Hospital and again required to contribute to patients' medical records. He said the medical records at Chelmsford were far inferior to those he had seen in the late 1960s.
- 296 The applicants' criticisms of Professor Parker's evidence, in my view, are unpersuasive. Professor Parker had worked in hospitals since 1967. The fact that he did not become familiar with private hospitals until later does not mean that his evidence about the unacceptable practices at Chelmsford was invalid. As he pointed out, poor practice was poor practice, irrespective of the nature of the hospital. The fact that he did not have access to other sources of information about the patients he considered does not undermine the weight of his opinions. The applicants have not tendered any material which would have the effect of undermining the value of Professor Parker's evidence. They put nothing to Professor Parker to suggest any opinion he formed might be wrong in the light of any additional document.
- 297 Professor Parker's concerns were not about mere record keeping. He explained in detail why record keeping was essential in a hospital setting, including in a private hospital where patients were admitted under a single physician. In any event, it is obvious from the Chelmsford nursing notes that Dr Bailey's patients were seen by Mr Herron and Dr Gardiner and were looked after by multiple nurses. The notion that a complete continuous record of care at Chelmsford was not required because it was a private hospital with patients admitted under the care of a doctor is untenable faced with the reality of day-to-day care at Chelmsford. Yet there was no such complete continuous record in evidence. Patients were thus subjected to a highly dangerous treatment without the basic safeguard of a continuous record of care (including review by doctors) being maintained. The fact that the Chelmsford system involved "nurses notes" rather than all medical notes (including by doctors) reflects the inappropriate fact that the nurses were routinely making life and death decisions about patient dosing with no input from the doctors and the doctors plainly believed that this model of patient care (or lack of care by doctors) was acceptable. This reflects also the fact that the entire admission process was left to the nurses with no apparent input from any doctor at the hospital. As Professor Parker said, this was never acceptable practice. Given the dangers inherent in the treatment it was a grossly negligent system of care.

298 Professor Parker's concern about the involvement of nurses in managing patient medications was sound. His evidence that DST involved complex polypharmacy which would have been difficult to manage even by a skilled anaesthetist, let alone nurses basing their responses on mere observations, was compelling. As I have said, the applicants' propositions about the role of the nurses and their capacity to titrate doses based on observations of the patients borders on fantasy. It pays no regard to the highly risky and complex nature of the drug regimen and the nurses' lack of expertise and capacity to manage what Professor Parker doubted a skilled anaesthetist could have managed.

299 Moreover, nothing in the cross-examination of Professor Parker came close to challenging his fundamental propositions (which I accept) that:

- (1) DST has never been established empirically as a valid treatment for specific psychiatric conditions or as a non-specific modality having benefit across a range of psychiatric conditions; and
- (2) the death of one patient alone at Chelmsford while under DST should have led to an immediate investigation. If a second gravid incident occurred the procedure should have been suspended or ceased until the causes had been identified and corrective strategies introduced if the procedure were to be continued. However, DST continued at Chelmsford after several patients had died which was unacceptable clinical practice.

## **6.5 Dr Jonathan Phillips**

300 Dr Phillips has practised as a psychiatrist since 1973. He became aware of DST in the mid-1970s and has been concerned about it since then. He was unaware of any scientific data to support the premise that "turning off" brain activity would allow the brain to regain equilibrium. He said there were many complications associated with DST with the greatest risk being pulmonary compromise due to immobility and as a result of the inhalation of vomitus not uncommonly following tube feeding. He described DST as an experimental procedure, which thus required fully informed consent. Dr Phillips examined certain patient files and concluded that the treatment of the patients was not acceptable according to the standards of the times and was so far removed from the actions of reasonable peers as to constitute negligence and medical malpractice. He considered DST not to be based on any sound medical premise and to conflict with the requirement that a doctor do no harm. He made the following additional points:

- (1) he knew of no Australian hospital treating psychiatric disorders with DST other than Chelmsford. Thus, peers of good standing at the time had rejected the treatment;
- (2) the practice of DST was not based on any acceptable scientific rationale which existed at the time. It appears to have been based on a loose premise of resting the brain but there is no scientific basis for this belief;
- (3) ECT, by contrast, was a respected form of treatment for a narrow group of psychiatric disorders. At the time, accepted clinical practice required ECT to be administered with a muscle relaxant and oxygen to avoid hypoxia or anoxia as a result of the seizure. ECT was administered at Chelmsford without a muscle relaxant and most probably without oxygen;
- (4) combining DST and ECT was an untested and risky procedure;
- (5) given the idiosyncratic and experimental nature of DST there was a need at the time to ensure the patient gave a properly informed consent. The Chelmsford notes examined by Dr Phillips did not suggest that patients gave properly informed consent to DST;
- (6) the numerous psychotropic agents used in the DST regime at Chelmsford had half-lives of sufficient duration to ensure sedation throughout a 24 hour period;
- (7) a patient undergoing DST is at risk for numerous physical problems including pneumonia, regurgitation of stomach contents, deep venous thrombosis, pulmonary embolism, pressure sores and dehydration. The minimum standard of treatment for managing such a patient would be in a high intensity medical ward or intensive care unit and certainly not a small private psychiatric clinic; and
- (8) each patient who was treated with DST at Chelmsford was managed in a non-acceptable/callous/reckless manner, with treatment placing each patient at risk for immediate complications, and adverse long-term consequences.

301 Dr Phillips confirmed that the passage of time had not caused him to change his opinions about DST. He still agreed with the opinions he held at the time when he first became aware of DST. His review of additional patient records which he had been provided to prepare his report for this proceeding had not led to him changing his views. He assumed the records were true and correct. He assumed the pleadings were true and correct. He accepted given his long involvement with matters involving DST at Chelmsford he had material in his mind from which he could not resile.

302 Dr Phillips said:

There is a distinct difference between the practice at Chelmsford which I have called and others have called deep sleep therapy ... and the practice of Dr Sargant and others in London, which could not be classified as DST.

303 He said that in his articles Dr Sargant repeatedly used the term “light narcosis” or “light sedation produced by a variety of drugs” which was different from DST as practised at Chelmsford.

304 He agreed that he was unaware of a paper by Dr David Moore published in 1958 about sleep therapy used on 86 patients at Royal Newcastle Hospital (“The Use of Sleep Therapy in Psychiatric Treatments” (January 4, 1958) Medical J Aust 9 (“**Sleep Therapy in Psychiatric Treatments**”). Nor did he recall mention of sleep therapy being used at Larundel Hospital in Melbourne. He was unaware of Dr Sinclair using sleep therapy in Melbourne but was aware of a 1991 report about sleep therapy in Victoria. He said:

...the critical issue is, what was sleep therapy in these centres? Was it deep sleep therapy as practised by Dr Bailey and Dr Herron, or was it some other form of narcosis? And without going into the papers you’ve quoted, I’m at a bit of a loss to know.

305 It was not put to Dr Phillips that these forms of sleep therapy were the same as the DST used at Chelmsford. He described DST as multi or polypharmacy to induce a high level of sedation, at least, most of the 24 hour period. He said:

I think, there was a rationale for narcosis therapy which has been talked about by various people over many years, but not for DST. And I tried, before, to make the separation between DST as it was practised at Chelmsford and narcosis i.e. sedation therapies used in other settings, for other reasons.

306 He gave this evidence about consent:

And what I want to suggest to you is the consent procedures in the 1960s and 70s were not the same as the consent procedures in the 1980s and 90s?---They were certainly loose. But with any form of unusual or novel therapy consent procedures, obviously, it would have needed to be tighter than they might have been in other settings.

And what occurred in the 1980s was there was an acknowledgement that there was no specific rules in relation to consent procedures for certain psychiatric treatments and that was sought to be legislated to clarify those issues?---We’re talking about formalised rules and I agree, entirely. I think, it’s important though, to recognise that the profession has unformalised guidelines and rules which we all accept and work within every day. And so I would not rule out the importance of consent at the earlier time, in any way.

Now, to the extent of unformalised rules, the place where those could be found would be in published literature. Is that right?---I think, the unformalised rules, principally, were in the collective head, if you like, of practitioners of the day. I mean, we, there’s a lot of communication between practitioners which relates to personal experiences, to what is thought to be good practice. And, of course, relates to published articles. But I, firmly believe, that in those years that I was practicing from the early 1970s, there



were a set of unformalised rules for consent. And I recall very clearly because we used them at the time, at the Northside Clinic where I then practised.

307 He did not accept that there was a difference between obtaining consent and recording consent, explaining that:

The information and the recording are one and the same. You can't – a consent procedure that is just a verbal procedure is worth nothing...

But there's a time-honoured dictum, in medicine, that one keeps clinical notes. And in terms of a clinical note, some entry into the file should always be made about a procedure as important as consent and I would not back away from that.

308 This exchange occurred:

Yes. But what I'm suggesting to you is that the recording of clinical notes or the recording of a consent procedure is for the doctor's protection, not for the patient's?--  
-I disagree with you. It is obviously helpful to the doctor to record those. But it's a communication device, not only for the doctor himself when he, or herself, when that doctor next returns, but for also for the nurses and any other people involved in the process of treating a patient. Clinical notes are extremely important.

Clinical notes by doctors over time vary greatly, haven't they?---I doubt it. I am very familiar with the clinical notes that were made by doctors in the early 1970s. And I doubt that they are much changed these days. Perhaps, there has been a greater use of pro forma documentation. I'm not even sure that that has been a particularly helpful exercise. But no, I don't. I don't think so. The principles have applied in the earlier years and the same principles apply today.

And I want to suggest to you that clinical notes in a private hospital were very different to clinical notes in a public hospital? ---I really have trouble with that. I – forgive me, I worked in a private hospital. It was a very well-respected private hospital with 21 psychiatrists working within it. And the clinical notes in the 1970s, which, I think, would have been equivalent of the clinical notes in other well-respected hospitals, were very good. And that includes, not only, the ongoing notes but the discharge summaries.

So you're talking about Northside Clinic, is that right? ---I am.

309 Dr Phillips rejected the notion that Chelmsford was not required to keep a complete and continuous patient record saying:

A hospital, a private hospital, at that time, as now, has to keep and had to keep a proper record of the patients. The record was a multi-person record. It was to be used by the doctors, the nurses, physiotherapists, if they were there, and other people, as well. So – no, the hospital records were critically important. Sure, the doctor probably held private records of consultations with the patient in his private rooms. But when the patient was at the hospital, an inpatient, then the record should have been maintained at the hospital for obvious safety reasons.

310 He said while intensive care units were a development of the early 1970s there were intensive beds long before that time.

311 He rejected the notion that the use of a Glissando ECT machine at Chelmsford made the use of a muscle relaxant unnecessary, saying:

I don't think it matters whether you're using glissando or square waves. I think a fit is a fit is a fit, and once the seizure is induced, there will be muscle movements. They will vary from patient to patient; quite minor to extremely aggressive.

312 He said irrespective of sedation the wisdom of the day was that ECT required anaesthetic, a muscle relaxant and oxygen and that had not changed since. He also said he disputed the acceptability of using ECT on adolescents saying:

One would think very hard before giving ECT to an adolescent because the brain is still in the stages of development. I'm not saying that there would be no case, but one would just proceed with enormous caution.

313 He also rejected the use of ECT for addiction in this exchange, albeit accepting that it was a matter of debate amongst psychiatrists at the time:

Now, I want to suggest to you that in the 1970s ... ECT was indicated for addiction? - --Yes. I have a major problem with that. I did not understand then why ECT per se should be used in a patient with addiction. I could not convince myself that there was merit in doing so, and I still don't believe that ECT is an appropriate treatment per se for addiction.

314 Dr Phillips confirmed his fundamental position about DST in this exchange:

We understand, Dr Phillips, that you're of the view that DST was not indicated for any psychiatric illness at that time. ---Is that right? That is correct.

And what you consider to be negligent and malpractice is the use of that treatment, at all? ---Fundamentally, that's true. I have criticisms of individual treatments at another level.

...

And, the premise of – the main premise of your criticism is, I think, you've said the pharmacology or the – sorry, you've used a different term this morning and I just can't place? ---I think the term I used this morning was 'polypharmacy'.

Yes. The polypharmacy of the medications that were being used in order to induce the sleep? ---Yes. It's not only the polypharmacy, but it's the very great difference between the English experience and DST. It's the drugs chosen, the use of barbiturates in high dosage, in particular, was a concern to me and more so, because they were mixed with a potpourri, really, of other drugs, as well.

315 Dr Phillips said he was not a pharmacologist but "the drugs used at – in the English series [Dr Sargent] were substantially different to the drugs used at Chelmsford, and that's a really important point."

316 Dr Phillips was asked about the fact that at Chelmsford the hospital's record was "nurses' notes" and said:

Well, I – forgive me, I don’t want to be difficult about this matter, but it is called the nurses’ record, but I have always thought of it, this record, as being the record. Now, I might be wrong, but if this is the nurse’s record, Chelmsford was way out of kilter with hospitals at the time, which had a multidisciplinary record.

...

I’ve made the assumption. I might be wrong, but I’ve made the assumption, and that’s – if it was just one person, I wouldn’t be all that worried, but it has repeatedly occurred for the Chelmsford files that there is a nursing record, but the entries by the doctors appear not to be anywhere in the file.

317 Dr Phillips said the general rule in the 1970s was that ECT should be given no more than three times a week. He was surprised at literature suggesting more frequent use because of the risk of cognitive damage.

318 Dr Phillips accepted that Dr Bailey was very charismatic and powerful in the psychiatric world and had been in practice for about 20 years by the early 1970s and had an extensive private practice. Dr Bailey spoke highly of his success with DST, Dr Phillips noting that “[d]efinitely he was – he was a very good – how should I put it, spokesman for himself.” Dr Phillips accepted that a general practitioner referring a patient to Dr Bailey would not be engaged in malpractice or negligence but said the good intention of general practitioners depended on if they knew the details of DST and the problems associated with it. He agreed with a proposition that it was not malpractice or negligence for a junior psychiatrist to consider it reasonable to use DST given Dr Bailey’s use of the treatment – but I should note immediately that this answer was difficult to reconcile with Dr Phillips’ observation that a doctor aware of the details of DST and of the problems associated with it would not or should not have referred a patient for DST. To a similar effect, when asked about the owner of Chelmsford in the early 1970s who was a GP considering DST an acceptable treatment Dr Phillips said:

A very difficult question to answer. I think that if an owner or operator of a hospital had taken full note of the problems that were associated with DST he or she would have come to a reasonable conclusion that deep sleep was an inappropriate form of therapy. On the other hand, if the owner or operator of the hospital, who presumably may have had a financial interest in the hospital, they may well have gone along with the idea that deep sleep was an appropriate form of therapy.

319 This exchange occurred:

Well, I want to suggest to you that any GP in that position, who understood the position of Dr Bailey, the fact that he had been using it for 10 years or more, the fact that it was based on – or said to be based on the work of Dr Sargant, who was eminent, any GP in that position would not have been engaging in medical negligence or malpractice by allowing Dr Bailey to continue that treatment in that hospital? ---I’ve suggested that such a person was acting in the manner you suggest – or you mentioned, sorry, not suggested.

I'm not saying you are, Doctor, I'm just asking whether you agree with me?--- I would agree with you.

320 Again, the obvious difficulty is that this cannot be reconciled with Dr Phillips' evidence that the position of a general practitioner would depend on their knowledge of the details of and problems associated with DST.

321 In re-examination Dr Phillips emphasised that his primary concern was not day-to-day patient care (although he had concerns about that from the records) but the issue of DST itself as practised at Chelmsford. He said:

...there is, behind the day to day treatment, a much bigger matter. And that is this most unusual form of therapy which was practised by various doctors at Chelmsford, beginning in the 60s and going into the 70s. And that is the elephant in the room.

322 Dr Phillips said that nothing that had been put to him altered his opinions that the treatment of each patient at Chelmsford with DST was not acceptable medical practice at the time, that Mr Herron and colleagues acted negligently and engaged in medical malpractice and failed to act in an ethically proper manner in administering DST to patients, as they should have known at the time not to treat patients with DST. Further, he said that the manager of Chelmsford, being a general practitioner, should have appreciated the potential danger associated with DST and DST and ECT in combination and should have stopped Mr Herron and colleagues pursuing this potentially dangerous form of treatment. Dr Phillips said:

There are two issues, from my perspective, in this case. And there are the day to day issues which were explored pretty much over the last two days in depth in relation to individual patients. That is one entity. The other entity is the entity of – is it relates to deep sleep therapy. The process of deep sleep therapy, which was practised at Chelmsford, and in my view was unique and different, say, from the British treatment. And the answer is different on each occasion. If I go back to the day to day management these are clinical management issues largely in the realm of general medicine, general practitioner medicine, and I responded to them as best I could. And, on the basis of that, it would be hard to say that negligence or malpractice or unethical practice would come into discussion. On the other hand, and if my report is taken in its totality, it's a report which goes to the process of deep sleep therapy and that is where I have really serious problems, and I have always had serious problems. I had them earlier, I have them now about not only the ethical nature of this practice but the clinical risk of this practice, because this, again I say, that this was a practice that was not followed, I believe, anywhere in the world, and that includes the English group.

...

DST in my mind remains an experimental form of treatment. In my view ECT should not have been used more than three times a week in association with DST because nobody knew what the combination could bring about.

323 Dr Phillips also explained that there were several differences between Dr Sargent's work and DST at Chelmsford:

I think it has to be said that Sargent and colleagues practised something quite different from deep sleep. They in fact used relatively light sedation over a period not exceeding 20 hours ever, as far as I understand, and light enough for the person to be walked to the toilet most of the time. Whilst deep sleep was a much heavier form of sedation. And it's also important to recognise that the drug regime was substantially different. The predominant drug regime used by Sargent and his colleagues was based on the major tranquiliser called promazine with the use of other drugs, but very carefully administered, mainly monoamine oxidase inhibitors, to keep the person in a light state, and a light trance. And it was – there was a comparatively simple regime. It changed over time, but the predominant regime was, in my – on my reading ... promazine and monoamine oxidase inhibitors. There is a stark difference, in my view, between that comparatively straightforward sedation therapy and the cocktail of drugs that was used at Chelmsford. I've been critical at various points in my report and in other places about the large number of pharmacological agents incorporated in the pro forma treatment sheet and used in the management of patients at Chelmsford Hospital. It would have been impossible for any clinician to predict what that combination of drugs was going to bring about. Keeping in mind that a number of the drugs had quite long half-lives, that the elimination of drugs from the body would have been slow and complex, and that, in my view, that the person would have been sedated at least to some degree though the 24 hours. There may have been periods where sedation was lighter, but for many people it would have been quite heavy during the 24 hours putting the person at substantial medical risk. Now, the medical risks of a heavily sedated unmoving patient are many. I addressed them in the – in my report, and just to pick up the major ones. Pulmonary complications, and particularly pneumonia, would be very high on the list. Deep venous thrombosis with a risk of pulmonary embolus would be very high on the list. Electrolyte imbalances, even malnutrition in the longer term, could become an issue because of the inadequate – or I think – believe the inadequate balance of fluids, which these patients were subjected to. And there were numerous other risks, including urinary tract infection and so on. They've actually been listed in my previous document. That is a better list than I've given here.

324 Dr Phillips said:

There were widely accepted standards of inpatient care at the time. One of my main concerns has always been that the standard of clinical note taking was nothing less than very bad at Chelmsford, and we struggled with the documents over the last two days, and almost without exception there were no entries in the clinical files made by the treating doctors at Chelmsford. It has been – it had been my view at the time and it remains my view, and I think shared by pretty much all medical colleagues, that if a person is seen by a doctor in a hospital it is critical to make a notation in the file. And Dr Milton has referred to that, I think he was referring to himself, where he talks about the importance of making a notation in the file. I have struggled over the last two days with the clinical records because the doctors' notations are not there. I don't know what was in the mind of the doctors. They should have been there for communication between staff at the time and, indeed, for review at a later time if necessary. So in that sense the way the doctors at Chelmsford carried out their business was very much out of kilter with what would have been seen as reasonable standards. And the failure to keep a proper clinical file in relation to many things, not only the running notes, but also the issue of consent, and other matters, is it remains a major concern for me.

325 Dr Phillips was asked to assume that Dr Gill was a general practitioner and administrator of Chelmsford from the early 1970s and the Dr Gill gave DST to six patients. He said:

Well, the answer is in line, obviously, with my earlier comment that if a doctor, a general practitioner or otherwise, had properly appraised, in a dispassionate manner, this complex and dangerous treatment of DST he would not have allowed any other person to practice it in his hospital. But behind that, and I touched on that in my answer yesterday too, was the ethical conundrum of whether a doctor should admit to a hospital he has a financial interest in and use a form of treatment which, I assume, was an income producing matter for the hospital. So I have a double problem, in essence.

326 The evidence continued in these terms:

The – a person who was the administrator of the hospital of Chelmsford who practised DST himself on at least six of his patients and who was also a GP – well obviously it had to be a GP if he or she administered DST, would that person, being the administrator – the GP who also administered DST himself, would that person have been acting negligently by doing so – by administering DST? ---I believe so. And I say, my definition of negligence – as reported in my document, was peer review-based. That peers of good standing at the time, if they looked at this complex action of a doctor in being the administrator, understand being a part owner, and then administering this form of treatment, I believe it would be – peers of good standing – majority of my colleagues would say this was inappropriate and, by the definition, was negligent practice.

And does that also apply to – well, I better ask in a non-leading way. Again, taking account of those assumptions and the one that you have added, that being a part owner, the conduct of administering DST amount to medical malpractice? ---Particularly, when you are a part owner of a hospital – because you are admitting to your own hospital, you are administering a most unusual form of treatment which is money making. And there needs to be a separation in medicine between these various matters. A doctor admits a patient to a hospital only for reasons of the treatment of the patient, not in any situation where money obtained from the admission becomes an issue.

Yes. I'm just not sure – can I just ask you this question, though: taking those assumptions into account, you have answered the question about negligence. Taking those same assumptions into account, does it also, in your view, amount to medical malpractice? ---Yes, it does. And keeping in mind what I had said in the report that in my view, malpractice and unethical practice underpin the negligence.

327 Dr Phillips also explained that when he had given his answer about a junior psychiatrist considering it reasonable to use DST given Dr Bailey's use of it, he had in mind a hypothetical junior psychiatrist, being:

... Someone who is within a few years of graduation who looks, at a distance, at what was being practised at Chelmsford, does not have a firm understanding of what was going on and would, in that situation, be likely to say well perhaps that could be the treatment for the patient I would like to refer. But it was a junior – hypothetical junior psychiatrist.

328 Dr Phillips did not consider that this could include Dr Herron (as he was) who could not have been seen as a junior psychiatrist at the time.

329 Dr Phillips was read an extract from Dr Moore's article "Sleep Therapy in Psychiatric Treatments" at 10 as follows:

The patients were allowed up to eat meals, go to toilet and bath, etcetera. They ate their meals together around a table so as to induce a group spirit and break down social isolation. A typical sleep chart for the day would be as follows:

Morning: from 9.15 am to 12 midday – ie, two and three-quarter hours.

Afternoon: from 1.15 pm to 4.15 pm – ie, three hours.

Night, from 9 pm to 6 am – ie, nine hours.

Total: 14 and three-quarter hours a day.

330 Dr Phillips said:

Dr Moore is talking about something quite different. To go back to narcosis or sedation, he was using a form of sedation therapy, but there's no parallel, as I read the material before me now, between what Dr Moore was doing at Royal Newcastle Hospital and the deep sleep therapy as it was practised at Chelmsford Hospital. He is basically establishing a regime where people are mildly sedated in the latter part of the morning and in the afternoon, it's almost like a double siesta. And I don't think that this can be logically compared to deep sleep therapy as it was practised at Chelmsford, which was a much more intensive form of sedation.

331 Dr Phillips reiterated his view that:

Deep sleep therapy was not an appropriate therapy to be used with anybody, and I'm talking about deep sleep therapy as it was practised at Chelmsford.

332 I do not accept the effect of the applicants' submissions about Dr Phillips' evidence. Dr Phillips' extreme criticisms of the applicants did not alter in his oral evidence. None of the oral evidence he gave undermined his opinion that, at the time, DST was an experimental and unproven therapy involving significant risks which should not have been administered to any patient. The fact that Dr Phillips had not conducted a full literature review is immaterial. The applicants have not proved that any of the literature which they tendered involved DST as administered at Chelmsford and, where there is comparative evidence, it is firmly to the effect that much of the literature concerns narcosis therapy which was materially different from DST, particularly the work of Dr Sargent on which the practice of DST at Chelmsford was said by Dr Bailey to be based.

333 Dr Phillips' view of the effect of DST on patients and their degree of sedation was not based on assumptions about the truth of the defences but, as is apparent from his evidence, his own opinions about the polypharmacy involved and the half-lives of the drugs used in DST. I do not accept the applicants' submission that it must be inferred that he was relying on the

assertion as to the depth of sedation in the defences. I consider this proposition irreconcilable with the substance of his evidence and his references to the polypharmacy involved in DST and the half-lives of the drugs involved.

334 The fact that Dr Phillips had a long involvement with the review of DST at Chelmsford and accepted that he could not remove that knowledge from his mind does not undermine the validity of the opinions he presented. The fact is he had a strongly adverse view of DST in the mid-1970s given his knowledge of what it involved and remains of that view. This does not mean it was impossible for the applicants to test his opinions. The applicants refrained from directly challenging Dr Phillips about the fundamental opinions he held that DST was a highly risky unproven and experimental procedure which should not have been administered to anyone either alone or in combination with ECT.

335 I do not agree that Dr Phillips' report should have been excluded under s 135 of the *Evidence Act 1995* (Cth) because its prejudicial effect outweighs its probative value. Dr Phillips is a highly qualified and experienced psychiatrist who was practising in the early 1970s. His evidence is of substantial probative value and is entitled to significant weight. The applicants were free to test all of the opinions which Dr Phillips expressed. They chose their forensic course by focusing on day-to-day treatment issues and hypotheticals rather than directly confronting the real thrust of Dr Phillips' evidence.

336 The fact that Dr Phillips had the nursing notes from Chelmsford and not other information does not undermine the validity of his opinions. The applicants did not put a single additional medical record to Dr Phillips or suggest to him that had he been aware of that record he may have changed his opinion. The applicants' criticisms in this regard involve pure speculation that some document might exist that might have changed Dr Phillips' opinion. Yet no such document was identified.

337 Dr Phillips' evidence about the day-to-day management of patients cannot be viewed in isolation from his fundamental opinions that no patient should have been subjected to DST and ECT as practised at Chelmsford. The fact that Dr Phillips was prepared to accept that certain (but by no means all) day-to-day responses to adverse reactions in patients were appropriate does not alter the fact that in his view the patients should not have been subjected at all to such a high risk, unproven, experimental procedure.



338 I do not accept that there was any irregularity in Dr Phillips being given overnight to prepare for his re-examination. Dr Phillips had been cross-examined for the best part of two days. He informed the Court through counsel at the end of his cross-examination that he was tired (consistent with my observations of him, particularly towards the end of his cross-examination) and would prefer to be re-examined the following day. The re-examination clarified opinions which Dr Phillips had given including towards the end of his cross-examination which were irreconcilable with his written and oral opinions to that point. The evidence given in re-examination is entitled to significant weight given that it explained the relationship between Dr Phillips' fundamental opinions about DST and the very lengthy evidence he gave in cross-examination about the day-to-day management of patients.

339 I accept Dr Phillips' opinion that the use of DST and the combination of DST and ECT used at Chelmsford was an unproven and experimental procedure involving a high level of risk which, at the time, should not have been administered to any patient. To subject a patient to DST, knowing of the polypharmacy it involved and the consequential risks, involved negligence, medical malpractice and was unethical in the sense Dr Phillips used those terms (that is, as a non-lawyer) because the treatment and its risks departed so far from what was acceptable medical practice to medical practitioners at the time. I also accept his opinion that administering ECT without a muscle relaxant and oxygen, which was frequently the case at Chelmsford for DST patients, was unacceptable practice at the time involving negligence, medical malpractice and was unethical in the same sense as Dr Phillips used those terms.

## **6.6 Professor Ian Hickie**

340 Professor Hickie identified coma based therapies as having entered psychiatry in the 1930s and continued until the early 1960s but that the toxicity and potential fatal outcomes involved were recognised and widely reported from the time of their initial use. Fatality rates of 2% to 5% were reported as were other non-fatal but serious medical (eg pneumonia) and neurological (eg hypoxic brain damage) complications at unacceptably high levels. Naso-gastric feeding was not considered desirable or reasonable as it was associated with severe risks (eg aspiration pneumonia). As a result, coma based therapies never entered standard practice as the obvious serious risks clearly outweighed any potential benefits. From the late 1950s onwards various medications became available that provided specific and much safer alternatives. Given the availability of alternative treatments with much lower risks of harm and much greater evidence of benefit by the mid to late 1960s a professional and ethically-based approach would require

the cessation of all coma based treatments. From the mid-1960s onwards any further development of coma based therapies could only be considered as experimental and well beyond the scope of normal practice. Any such further experimental practice would have to be carried out at an accredited centre and meet the following requirements: (i) appropriate ethical and clinical governance, (ii) specialist medical and nursing capacity to ensure safety of patients, (iii) provision of clear information to patients about the experimental nature of the procedures and of the likely risks including brain damage and death, (iv) independent clinical and ethical review, and (v) reporting of results including continuous monitoring of adverse events in a clear and transparent manner to the appropriate medical and professional authorities as well as the peer reviewed clinical and scientific literature.

341 Professor Hickie said normal professional behaviour during the period of the administration of DST at Chelmsford required:

- i) Detailed medical, psychiatric and neuropsychological assessment of patients prior to administration of the treatment – and exclusion from such treatments of any individuals who would have been at substantially increased risk (e.g. due to age, medical morbidity, previous brain injury) as a consequence of exposure to the treatment;
- ii) Clear evidence of the written and informed consent of each patient to the full nature and extent, including the likely risk, of exposure to the treatment;
- iii) Detailed written protocols for the general and safe administration of the treatment, including specific modification of instructions for each patient (e.g dosage of medications);
- iv) Frequent (ie at least daily) specialist medical review of the medical state of the patients exposed to this treatment;
- v) Close supervision of the practices of all other nursing and health staff engaged in the care of these patients;
- vi) Detailed medical, psychiatric and neuropsychological assessment of patients at the completion of the treatment;
- vii) Systematic collection of clinical data detailing the rates and types of medical complications of treatment; and,
- viii) Reporting of serious adverse events to independent clinical governance of the Chelmsford Hospital and independent medical authorities.

342 According to Professor Hickie at the time of administration of DST at Chelmsford the expected ethical and professional standards that were in operation included that:

- i) Specialist psychiatrists, and other physicians assisting the administration of treatments, be aware of the commonly accepted forms of treatment (eg psychotropic medications, psychological and behavioural therapies) available for the management of common mental disorders, such as anxiety, depression

and related substance misuse.

- ii) 'Deep sleep therapy', other coma-based therapies and unmodified ECT, were not among the commonly accepted treatments that should have been offered to patients presenting with these conditions;
- iii) If exposing patients to 'experimental' therapies was a proposed course of action, then the specialist psychiatrist should provide patients with all relevant information with regards to the rationale for the recommendation, the proposed benefits of the treatment as compared with standard therapies and, most importantly, the known or likely risks associated with the 'experimental' therapies. Given the long history of these 'coma-based' treatments this would have included detailed information with regards to the fatality rate (2-5%) and the serious medical complication rate (at least 10-20%);
- iv) Given the known long history of serious adverse effects of 'coma' therapies, approval for the use of such 'experimental' and high-risk approaches should have been subject to prior approval by an independent medical body and an appropriate ethics and research committee;
- v) After commencing the 'treatment' the serious adverse events that occurred at Chelmsford should have been systematically documented and reported independently to relevant medical and professional bodies. The rate of serious adverse events should have led to the rapid cessation of the practice, pending review by independent medical experts.

343 In Professor Hickie's view, for these reasons:

...a clinician (and specifically including a specialist psychiatrist or a general physician) who was providing the 'treatment' described, in the setting provided at Chelmsford Private Hospital, and in the 1970s, was acting negligently, unethically and was engaged in medical malpractice.

...

To have acted ethically, the responsible clinician should have proceeded on the basis that the proposed treatment was 'experimental' and then sought to have the whole process considered to be a clinical trial of this treatment. Within that framework, the 'experimental' nature of the treatment would need to have been set out under an appropriate ethical and clinical trial governance framework. This would have resulted in the proposed treatment, and the administering site for that treatment, becoming the subject of review by independent professional and ethical bodies.

344 He further considered that, for the same reasons:

...the manager of a hospital (given that such a person had medical expertise) that was administering the treatment, (for the reasons outlined for the responsible clinician) would also have acted negligently and unethically, and would also have engaged in medical malpractice.

...

To have acted ethically, the manager of a hospital should have rejected the proposed treatment as standard or acceptable medical practice. Further, the manager should have clearly stated that the facility did not have the required level of medical or nursing supervision in place to manage patients receiving the treatment described. Once the rate of adverse events was clearly evident, including any specific fatality, the manager

should have acted immediately to terminate the provision of these treatments in this facility.

345 Professor Hickie started medical practice in 1982 and became a registrar in psychiatry in 1984. He worked in large public hospitals and did not work in any private hospital. He assumed that he could base his opinions about DST at Chelmsford on the allegations of fact in the defences. He agreed he had referred to only one text in his report (Shorter E, *The History of Psychiatry in Australia*, (John Wiley & Sons, 1997) (*History of Psychiatry*)) but said his training in these areas is extensive. By this I took it that Professor Hickie considered he had extensive expertise in respect of the history of psychiatry in Australia. Professor Hickie confirmed that the standards are “continuously improving in relation to the regulation of experimental practice in psychiatry, as with the entire field of experimental medicine”. However, he also considered that:

...the ethical frameworks have not altered greatly in relation to the obligation of practitioners to observe, particularly in areas of experimental medicine, the accurate recording of the benefits, the risks, the harms that may occur.

346 He said that:

...the accurate recording of benefits or risks is what has driven practice. I would say particularly from periods when there was clearly abuse of psychiatry in certain situations, both during the Second World War and subsequently in the Soviet Union, a great deal of emphasis since the 1950s has been on the appropriate ethical practice, particularly in areas of experimental medicine, in psychiatry in particular, as compared with other areas because of the vulnerability, potentially, of the patient groups that we deal with.

347 He said that:

...while coma-based therapies were a subject of experimentation, along with ECT and psychosurgery in the 1930s, when there were no other pharmacological treatments available, they largely fell into disrepute because of the adverse effects that they led to. So the issue of experimentation is an important one and of innovation, but that is always weighed up against the risks and the benefit, and the accurate recording of the benefits versus the outcomes and the risks, and the adequate communication to people participating in experimental treatments – that has not changed, and so we had interventions that were trialled in the 1930s, some of which persist. So in the case of ECT, which was also first used at that stage, prior to the modern pharmacotherapy age, it continues in treatment, although modified in its form, because of the risk/benefit ratio. There are some – still some forms of new brain surgery in different form that are still the subject of ongoing experimentation in ways that reduce the risk, so what happens in the process here is a continuous evaluation, an independent evaluation of the risks and benefits under the appropriate ethical framework, so the methods – the ethical processes and the methods for recording haven’t changed greatly. The interventions themselves change and are used, and then continued, and modified or ceased, depending on the outcome of that evidence.

348 He rejected the proposition that the ethical standards in the 1960s differed from those today saying:

I do not agree. I think, in fact, it was very important historically here, both what was the situation in the 1930s, what led to the cessation of various treatments, and particularly following the second World War, and particularly psychiatry being particularly sensitive about the extent to which it had been abused in those periods of the middle of the last century. That the ethical framework was well-recognised, and the need if you were involved in any interventions, particularly in these periods, to behave ethically. And that means from a scientific point of view, if you are trialling a new intervention, to accurately record, put the rationale forward and have that reviewed by peers. Describe the protocol, have that reviewed by peers. If you engage in that particular practice, that you record accurately the benefits, the risks and the harms, and you continue to report those externally and transparently. I do not think the ethical framework has changed at all.

...

The methods for recording it have [changed], not the obligations. The issues of ethics committees, independent oversight, journal publications, peer review, protocols has not changed at all. This is a well-established practice in medical research, as it has been. And the abuse, in fact, in psychiatry in the middle of last century, led to generally a greater focus on being careful about these issues, and particularly given the vulnerable populations, and that remains the case today. For ethics committees, for other independent reviews, these things are subject to a great deal more review, and an expert and independent review from those who are actually conducting the interventions.

349 He said:

...Again, the reason why I quote particularly, Professor Shorter's book, is to understand the transition here between the 1950s and sixties, into the 1970s, with the arrival of modern pharmacotherapy. So the other issue in medicine always in standard practice, is what are the alternatives that are available at that period. So the situation in the 1970s through to the 1980s, was very different to the 1930s and forties, and certainly up until the late 1950s, early 1960s.

350 Professor Hickie gave this evidence:

One way to determine whether or not – or how to conduct a treatment is to visit a facility that has been conducting it for some time and to observe and learn from that facility. Would that have been a reasonable step for a practitioner to take in the 1970s?--Yes.

And another step that a reasonable practitioner could take is to identify the fact that eminent psychiatrists were using a certain treatment in a particular way that would be a way for psychiatrists to give him or herself comfort as to whether or not that treatment was acceptable. Is that right?---That may be one more step of many steps that you might take, if you're involved in treatments that you know involve considerable risk – one of many.

And one of the other factors that needs to be taken into account insofar as risk is concerned are – is whether there are reported studies that the treatment in question is indicated for certain conditions; is that right?---That would be one issue. Again, professional practice at the time and what is accepted doesn't necessarily reflect what

one particular review or one particular author's view might be, historically, or any particular issues. The issues of best practice in professions is a professional issue, so various bodies do often issue guidelines and issue statements. And there are best practice approaches, particularly in treatments that involve considerable risk, even if those treatments are no longer the subject of experimental enquiry.

351 Professor Hickie agreed that he had not reviewed literature "that applied or was available in the 1960s and 70s as to how psychiatrists should conduct themselves in relation to the use of what [he had] called experimental treatments" and that he was not in practice at that time. However, he said:

No. I haven't referenced it [the literature], but if you go to any standard hospital, in terms of its protocols for delivery – and the hospitals I worked in – in – and as a medical student in the 1970s, as a doctor in the 1980s and onwards, those protocols for those treatments as they surround other protocols for the delivery of anaesthetics, as they ... surgery in other areas – what are the standard hospital protocols for delivery of the treatment, also for the recording of effects, also for the availability of staff to monitor those effects, also the qualifications of staff to deliver those particular settings. They are the standard protocols. So I have not referenced each of the protocols in each of the hospitals at those times because that's not a matter of literature review, that's a matter of protocols and professional and ethical practice.

...

So reasonable hospitals and reasonable practitioners have available protocols in their hospitals for what the treatment is, who delivers it, under what circumstances, with what review on an ongoing basis, just as they have protocols for surgery, just as they have protocols for anaesthesia, just as they have protocols for other standard practice. So hospitals have those. They're often overseen and initiated by the clinical leadership and approved by the hospital administrations and they pay respect to professional standards of practice at the time.

...

Now, I could also make the point nothing has changed here. These have been the normal practices in our hospitals for a very long time, and certainly back into the 1970s and 1960s, and really to ensure, particularly in psychiatric practice, that we behaved in ways similar to our surgical and medical colleagues, to make our practices actually transparent and clear and overseen in the appropriate ways, particularly given the vulnerable nature of the populations that we often deal with.

352 Professor Hickie rejected the suggestion that the use of rapid neuroleptization in the treatment of schizophrenia in Australia in the 1970s did not meet the ethical standards he had described in his report, saying:

And I don't agree with you, because the issues around the ethical practice in a particular areas and the adequate and monitoring and recording at the facility level of what is normal practice and making sure that happens in a safe way, I would suggest to you, were followed in the 1970s and through to the 1980s in appropriate facilities by appropriate practitioners.

353 Professor Hickie considered the history of narcosis therapies disclosed that they were focused on restoring a proper sleep/wake cycle rather than sedating a person for 24 hours a day. Professor Hickie explained he had a particular interest in this area of research and a large part of his work over his career had been taken up with the issue of sleep/wake cycles and the attempts over the history of psychiatry to restore these cycles. He said that before the 1960s barbiturates were the principal drug for sedation but by the 1960s many safer and more effective treatments became available and then in the 1970s benzodiazepines and other drugs were also much safer for sedation. As a result, practice moved rapidly away from the prior treatments which were known to have high mortality rates and considerable other risks to more effective and safer methods. He explained that:

What is well recognised about sedation at this level at this period of time in any setting is the potential risks. Suppressing breathing, actually causing other complications of those particular factors, aspiration pneumonia, swallowing your vomit, complications in terms of pneumonia and infection, hypoxia in having low blood oxygen delivered to the brain. There are a range of intrinsic risks associated with it and depending on the setting in which you conduct it, you've got to assume there's at least a mortality rate in the one to two per cent range and depending on how you do it, it may be as high as was reported. This is not simply a function of the drug. It's a function of dose, protocol, safety and monitoring. As with any of these particular treatments or with any other medical treatment that involves this degree of risk. The mortality ratio will be a function. So what this is indicating historically is the range in which this has occurred.

354 The reported mortality level from narcosis therapy according to Professor Hickie was between 2% and 5%.

355 Professor Hickie was familiar with the work of Dr Sargant and said that it could not be assumed that the therapies Dr Sargant was using could be compared to DST as practised at Chelmsford. He said that in any event by the 1970s:

...other safer and more effective treatments had delivered, the notion of coma-based therapies and particularly of deep sleep continued unconsciousness as being a way forward had largely been abandoned by the experimental end of the profession and also by common practice.

356 In response to a proposition that Dr Bailey had claimed he had treated 2000 patients with DST since 1951 Professor Hickie said:

I would like to see the systematic evidence. Simply the fact that Dr Bailey made such a claim, I would like to see the details, and not only that, the extent to which – between 1951 and 1967, as you suggest, the method was the same. I would be very surprised if the methods in 1967, were the same as those in 1951. The mortality rates, the outcomes, etcetera. So I think that is simply, as people often do, saying 'I have a lot of experience in a particular area,' without providing the style of information that lends itself to external review.

357 This evidence was then given:

Well, you're not suggesting, are you, that if a practitioner makes an adjustment, any adjustment to a therapy that they've been undertaking for many years, they are required to undergo the protocols that you've discussed today, and in your report?---I am suggesting that if you encourage experimentation with an area, if you are involved in experimentation or significant deviation from accepted practice, I am suggesting you should do exactly that.

So ?---If you are departing from, and particularly if you are exposing people to risks associated, and you know that, and every medical practitioner knows the serious complications of prolonged sedation, from any course. Any medical practitioner is aware of that, that that is a significant risk, that certain groups of patients are in danger as a consequence of that approach, for whatever medical reason it's undertaken. So significant deviations from that, I would expect to be subject to independent review by peers, and where appropriate by independent ethical review committees and tribunals.

358 According to Professor Hickie:

... in relation to the schedule of the treatment provided at Chelmsford Hospital, I think it is clear that it is grossly inadequate for the provision of anything that involves prolonged unconsciousness.

359 This exchange then occurred:

Professor Hickie, you have not done a literature review, have you, of the available literature to a practitioner in the 1970s, in relation to deep sleep therapy or prolonged narcosis, or modified narcosis, have you?---No, I have not done my own literature review. No, but I am a trained practitioner in these areas, with an extensive knowledge of the history of these approaches, and also as a trained physician, of the intrinsic risks associated with prolonged sleep. Also as I've made clear, it is an area of my professional expertise, in terms of the restoration of ... cycles and the history of that.

Well, I want to suggest to you, Professor, in order to determine whether Harry Bailey significantly deviated from the practices of others who had published studies, you would need to closely review what those practices of others were, as published in the studies. Wouldn't you?---There are studies. There is also the common practices of other practitioners during this period, and again I refer you back to the Shorter book, that by the 1960s, other safer and effective treatments had emerged.

360 Professor Hickie did not see the existence of other publications after the 1960s (by Dr Sargent in particular) as altering the fact that there had been a:

...fundamental change in the direction of practice away from this style of treatments, due to its morbidity and its problems. The fact that practitioners who – Sargent, who had been practicing in the 1940s, may have continued with some aspects of that, does not indicate the clear change in practice in the late 1960s, mid to late 1960s, away from these styles of treatments due to their risks even in the best of circumstances, because of the development of safer and more effective treatments.

361 When other literature was put to him that he had not read (being that relied on by the applicants to support the asserted efficacy of narcosis therapy) Professor Hickie said:



Again, I would make the general comment here, there are many publications that may have occurred during that particular period. The key issue here, I think well summarised by Shorter, is because of the modern pharmacotherapy era, the movement away – so while studies may well have been conducted during that period, the relevance here is the fundamental shift in a direction towards safer and more effective treatments, with the modern birth of pharmacotherapy.

362 This exchange then occurred:

And if those journals explained – or set out the methods used being used by the practitioners, the results that they achieved and the indications for the treatment – that would be something that a reasonable medical practitioner at the time could take into account in considering whether or not they should use the treatment?---It may – it may be one factor that informs their decision about practice.

Now, in relation to ? ---I would make the comment it's not necessarily sufficient. It may inform, and for many treatments actually simply reading about or knowing that a treatment may be effective doesn't mean you necessarily are able to provide that treatment safely or appropriately in your own setting.

Well, there's no universal agreement, is there, among psychiatrists as to which therapies are medically acceptable and which ones aren't? ---No. I don't agree about that either. I think there are standards of practice and they're agreed in the professional groups. Some are the subject of an external review and regulation, as we discussed earlier on. Some are prohibited in certain circumstances, and, actually, as time develops, what are the appropriate standards of the day – and the general movement towards safer and more-effective treatments and moving away from treatments that may have been effective, but were associated with undue harm is clearly part of the continuing development of appropriate practice.

Well, putting the two extremes aside, banned practices and practices that are widely accepted, the practices you've just referred to at the end of your answer are not at every point in time the subject of consensus in relation to whether or not they're medically acceptable? ---Within – again, I – I don't necessarily agree with you about that. I think there are often a range of practices that are accepted – that are acceptable, but which ones are deployed in certain situations – for example, there are various forms of medication therapies. There are various forms of psychological therapy. They're very different. They may be both appropriate in a particular situation. They're within the range of treatments that might be continued. Some practitioners better trained in one may well deliver one. Some better trained in others may deliver the other. So there's a range of accepted treatments at any particular point in time. So different treatments may be delivered, but there's still often an acceptance of the range of reasonable practice.

363 While Professor Hickie accepted as a generality that some practitioners might engage in a therapy longer than others, it was different if the treatment involved a risk of significant harm. He said:

No. I don't agree with you. No. I don't agree with you on that particular point because if it's – if any of the treatments you're describing runs the risk of exposing the person to significant harm, including death, that is not the same as a debate about one medication versus another or psychological therapy versus another. When there are significant risks and harms at stake, this is not an issue then of just individual decision-making or 'I prefer to continue a practice that I've been continuing since the 1950s or

1940s.’

Well ? ---That is not – where there is significant risk at stake, that is not simply a matter then of individual judgment or opinion or experience.

364 He continued:

...I’m referring to the schedule and what is described as the treatment because in that area I think it is absolutely clear that what is described in the treatment provided to me I would consider entirely unacceptable by comparable standards in the 1970s, and it doesn’t just relate to whether a practitioner was trying to induce sleep or a condition of prolonged sleep. It refers to the entire setting and the risks associated with that, which strikes me, frankly, as something that you would have seen perhaps in the 1930s or forties, and even then, and as pointed out by himself in the Slater article [Sargant W and Slater E, *An Introduction to Physical Methods of Treatment in Psychiatry*, (5th ed, Science House, 1972 (*Introduction to Physical Methods of Treatment in Psychiatry*))], that actually people did not attempt to keep people asleep for actually 24-hour periods or prolonged periods. The development of these areas – and as pointed out by Shorter, by the end of the 1960s, that whole concept had been moved away from. So the issue here of what is described in the schedule, which is not just a focus on sleep; it’s prolonged unconsciousness and ECT and, in my view, grossly inadequate supervision of that particular set of circumstances – is clearly a variation. That does not require a review of the previous 50 years of deep sleep therapy. It requires comparison with normal practices for any of those particular issues. Firstly, what’s the justification since, as well described by Shorter, the rest of practice had clearly moved away a decade earlier from that particular set of areas? Second, even if it was continued, was it done with reasonable consideration to the safety of the actual patients subject to that? You’ve raised other issues as to whether it is actually comparable, even as indications with the very severe illnesses of people who, in earlier periods, were hospitalised, often permanently, for their conditions, as distinct from people attending outpatient practice, coming along in a voluntary condition to receive treatment. So I think I don’t agree with – I agree certain aspects – comparability with the day, yes. In terms of actually being able to assess that, that doesn’t require a complete review of what was normal practice in the 1930s, but actually what would have been safe practice in the 1970s and the justification for that practice and the adequate supervision of that practice, and what would have been the view of external colleagues during that particular period with regards to the treatment as its described here. Not a focus on sleep, but a focus on the entire way in which the treatment has been delivered, supervised and monitored.

365 The schedule Professor Hickie is referring to is a schedule provided to him in his letter of instruction about DST as practised at Chelmsford. That schedule is annexed at Annexure A to these reasons for judgment [EXP 56.3 to 56.6]. Based on the whole of the evidence (including my examination of numerous nursing notes from Chelmsford and the expert evidence) I consider that the matters described under the heading “Treatment” in that schedule are a generally accurate description of DST and ECT as administered at Chelmsford other than to the extent that the evidence discloses:

- (1) the level of sedation of patients varied over the course of the 24 hour period but the inferred objective of the polypharmacy involved was manifestly to achieve as near as

possible 24 hours of deep sedation where patients would tolerate a naso-gastric tube and often be incontinent. At this level of sedation some patients would have been unresponsive to painful stimuli but as dose periods came to an end, depending on the individual patient, patients may have become rousable and, on occasions, were capable of being assisted to a commode for toileting;

- (2) ECT was not administered every day to every patient, although it was administered daily to some patients. It was routinely administered to DST patients without a muscle relaxant, oxygen or anaesthetic, contrary to standard practices at the time;
- (3) the nurses conducted an admission process in which they would take a patient history to some extent and order a range of routine tests. Doctors were not generally present at the admission and thus the patient would be admitted without a doctor giving the patient a physical examination at that time. Some patients may have been the subject of physical examination by a doctor in their private practice suites before admission but none of the results of those examinations form part of the continuous medical record of care at Chelmsford, contrary to standard practice at the time;
- (4) it is not entirely clear whether there was always only one registered nurse on duty for the entire hospital. Some evidence suggests that there were shifts when two registered nurses were on duty; and
- (5) it may have been that there were six rather than eight patients undergoing DST at any one time. The evidence is unclear.

366 I do not consider any inaccuracy in the description of the “Treatment” in the schedule to be material by reason of these matters. The essential aspects of the description accord with the weight of the evidence. The applicants’ submissions to the contrary are unpersuasive. Accordingly, Professor Hickie’s evidence cannot be discounted due to any unreliability in his assumptions. It is also evident that his assumptions were confined to DST as practised at Chelmsford – the balance of his evidence about narcosis therapy and it being outmoded by the 1960s was based on his medical expertise.

367 Professor Hickie explained that with the availability of alternative treatments in the 1960s and 1970s he could not see:

...any conditions would be appropriate for deep sleep therapy. I don’t believe there are any indications for deep sleep therapy. I don’t believe there were any indications in the 1970s for deep sleep therapies. In fact, the issue that you’ve raised – for each of the conditions named, more specific treatments at lower risk had already emerged.

...

We had the development of many, many other classes of drugs that, for the great majority of practitioners, meant there was no indication for anything – anything even mildly resembling deep sleep therapy.

368 Professor Hickie refuted the notion that the new drugs that became available from the 1960s were themselves experimental, saying:

No. It was not experimental. So this is an important point. When things moves from experimental to regulatory practice, there are things and areas of experiments at certain points and we have regulators in Australia. We have the Therapeutic Goods Administration. We have the Food and Drug Administration in the United States, elsewhere. That things have reached a certain level of safety by continuous evaluation and efficacy. They are then regulated to move into normal practice. They're then regulated and – and supplied that they are fit for practice in those areas. Now, what happens in post-surveillance of that regulation is things may well then emerge when 10,000 people are exposed to that treatment when previously there may have only been 1000 and that is the post-marketing or the post-treatment surveillance that goes on. That is not experimental. That is the appropriate surveillance of that common treatment in common practice.

369 He explained that with respect to DST by the 1960s and 1970s:

I cannot think though in my whole professional experience of a scenario in which any of those treatments in terms of the risks involved or this would be the next reasonable step... I cannot think of a possible scenario in which what you describe would result in the offer of this treatment.

370 As to consent, Professor Hickie said:

The standard of consent, again, is not something that has fundamentally changed over that period. The standards of providing consent – how you're providing consent and the way in which you may be required to do it, but the fundamentals of informing people about the options available in terms of treatment and the risks of which are you exposing them and also what is common practice in that area and if you are exposing them to something that is not in common practice – it's not something happening at another hospital down the road or in three other places or where you could go to four other practitioners and have the same treatment, then the issues in relation to informed consent, I would suggest, have not changed at all.

Well, I want to suggest to you there was, in fact, substantial legislative changes made on the question of consent as a result of a review of consent procedures in 1986. Are you aware of that? ---That's the legislative change. I'm referring to here the practices in the ... for what medical practitioners would be reasonably expected to do. The fact that legislation has moved over time and we have seen – this goes back to a methods question of some hours ago – as to how we record these things and how we document and how we provide information to people, but the fundamentals, I would suggest, have not changed at all. The medical issues here – and I go back again to the period – just to go back to – particularly in relation to psychiatry, back to the periods – the very adverse experiences that we had in the 1930s and subsequently the Eastern Bloc countries. The issues of vulnerable patient populations being provided with adequate information about alternatives, about the nature of the treatment, about the risks and the onus on any psychiatrist in this area to be particularly vigilant around the issues of

consent to treatment, particularly where the treatment has clear risks, I would suggest, have not changed at all.

Well, Professor Hickie, you weren't in practice in the 1960s and '70s; correct? ---No. I was a medical student in the 1970s and doctor practicing in my own right in the 1980s.

And the question is, what are ? ---Yes, but on a qualification of that, the teaching of consent, the history of consent, the history of medical practice did not radically change in those periods of the ethical – I think the big changes I've alluded to, and particularly in psychiatry, which is a particularly sensitive issue for those of us trained in the 1970s, was to be extremely aware of these issues because of the very adverse effects on the practice of psychiatry, and the reputation of psychiatry out of the Nazi period and the Soviet War period. So I think the issues were well-known and taught to practitioners like myself in the 1970s. That these were issues that, in practice, required a great deal of attention for all medical practitioners, but particularly for those dealing with vulnerable populations.

And what I want to suggest to you, if there was a specific requirement as opposed to best practice in relation to issues of consent at that time, there would be literature available to those practitioners practicing in the 1960s and seventies, to have regard to on that issue? ---Well, they may or may not refer to the literature on the issue. But again, the issues of the ethics of practice as a practitioner, within the professions that you were dealing with, were well-taught to medical practitioners, and the high standard at which they were expected to behave, and I would say particularly for those of us training in and practicing in psychiatry, these issues were, and continue to be, emphasised. This was not something that just happened in the 1980s or the 1990s, or subsequently. These were issues that were unfortunately highlighted for us by what happened in the 1930s and onwards, elsewhere in the world, and the issue of vulnerable populations and appropriate practice was, as I say in my own experience of being taught when I was a student in the 1970s and into practice, it wasn't something that was just invented at a later period, or simply became the subject of a legislation at a later period.

Well, first of all, you were being taught it in the 1970s, but you don't know what was being taught in the 1940s or fifties, is that right? ---I would hope that what was being practiced in the 1970s, reflected the practice of the 1970s, and not what was taught in the 1940s or fifties.

And there's ? ---And I don't accept your proposition, actually, I don't accept that actually, there are many issues of ethical practices that have continued. I think what was [said] for psychiatry, is that in certain parts of the world, in fact, practice deviated significantly, and particularly in Nazi Germany, and particularly in some Soviet bloc countries. The ethics of this run back over a long period. So even in the 1940s, I would expect that the same things were taught. It has a long tradition, and the issue of vulnerable populations has a long tradition.

...

If you are practicing as a medical practitioner throughout the whole of your education and ongoing practice, you would be aware of the stems of these issues. It's not simply a matter of what is written down at a particular point, these are continuing ethical principles. They were not invented in the 1980s or the 1970s. They applied in the 1930s, so we apply them, and we abhor the practices that undertook it under countries at that time, which clearly broke those principles. And we see them in other situations, where we think they have again been ignored, and I'm afraid to say that appears to be the case in Chelmsford, in the 1970s.

...

Well, I want to suggest to you that as far as informed consent is concerned, in Australia at least, the notion of informed consent from a legal perspective, didn't develop until the 1980s? ---The legal stance, the way in which the methods were required to be recorded and acted, have been subject to continuous review. So we find ourselves now in a situation where the degree of reporting, recording of changes and standards, have been set down, where they've been set down in regulation, where they've been set down in legislation. That hasn't changed the ethical principles that have underpinned practice.

371 As to the fact that muscle relaxants were not routinely used at Chelmsford in administering ECT (a fact apparent from the medical records), Professor Hickie gave this evidence:

...if you assume please, I don't know if it's in there, but if you assume for a moment please that there was no fractures, and no dislocations evidenced amongst thousands of ECTs performed at the hospital, over a period of years. Would that be relevant in your assessment, as to whether or not muscle relaxant was a necessary part of the provision of ECTs to sedated patients?--- No.

372 Professor Hickie was not familiar with ECT using the glissando technique but said:

An important clarification. If a person has a convulsion by whatever method, by whatever machine, the issue of complications is not simply one of fractures.

...

A fracture is one complication of the lack of muscle relaxants. If you have a seizure, if you have epilepsy, if you fall in the street, if you have – the issue of muscle contractions and their adverse effects. So if you are delivering ECT by whatever method that results in a seizure, the standard practice would be to provide muscle relaxants... Not simply to avoid fractures, to avoid a whole range of injuries... Including dislocation... Including tissue damage.

373 This exchange occurred:

...if you assume, for a moment, that amongst thousands of ECTs, there is either no evidence or no evidence of any significant reporting of such results, as a result of ECT. You couldn't exclude, could you, the possibility that the fact that the patients were sedated, meant that the impact of the seizure was different to how it is conducted by other practitioners? --- I can't accept your assumption. I can't see evidence of what you're saying, assuming that for that many ECTs, as if there were no actual adverse events. In the material provided, there's listed a random sample of 200 patients, and this would depend, of course, on the recording. This would depend on the open and transparent recording in real time of the complications, including the range of complications from unmodified ECT. So you know, I think the assumption that you've asked me to make, are not assumptions that I could accept without seeing actually adequate evidence to support those assumptions.

So you refuse to accept those assumptions? --- I can't see – the proposition you're putting to me is nonsensical, in terms of the risks associated with unmodified ECT. But there is some form of ECT that results in a seizure. There are different – now, it's important to say here, there are different kinds of brain stimulation techniques, so that many situations now don't require – that involve brain stimulation in one sense or another do not resolve in a seizure. So I'm not sure whether what you're suggesting is

that the ECT that was delivered did or did not result in a seizure.

Well, what I'm suggesting, Professor, is that Dr Bailey used an ECT machine that's not standard and as used by other practitioners at that time. --- But as I understand it, you're not familiar with how that ECT machine operated; is that right? I'm asking you, did it result in a seizure?

I'm not sure I have to answer questions, Professor. But what I'm asking ? --- I can't answer – I can't answer your question without knowing – when you say he used an ECT machine, assume it had no effects. There's a chain of events. If he's using an ECT machine to induce a seizure and a patient has actually had seizures, then I would find it hard to assume – and unmodified, without appropriate muscle relaxant – that there would be no complications of that. That would be highly inconsistent with the rest of the professional literature about unmodified ECT.

You have assumed, haven't you – and this is no criticism, Professor – that the ECT technique being used by Dr Bailey and the other doctors at Chelmsford was the same as – putting aside, of course, the muscle relaxant issue, the ECT machines being used by the doctors at Chelmsford have the same effect by way of seizure as other ECT machines being used at that time? --- I am assuming that when someone uses the term ECT, they're involved in a procedure that causes a seizure. If the patients actually had a seizure which has actually got to do with the therapeutic effect of the treatment, and that was unmodified without muscle relaxants, I would find it astonishing if there were no actual musculoskeletal complications of that treatment.

374 It may be recorded here that there is no doubt that the ECT machine used at Chelmsford was used to induce a seizure in the patient.

375 As to the practice of DST at Chelmsford involving patients being incontinent and wetting the bed, Professor Hickie said:

There are two aspects here. It goes back, in fact, to your earlier reference to Slater [Sargant and Slater, *Introduction to Physical Methods of Treatment in Psychiatry*]. In most of the areas in which anyone is using any modification of any kind of sedation therapy, the usual practice would be, in fact, that people are not so sedated that they cannot, in fact, toilet themselves or be assisted to toilet. The idea that they would lie incontinent, from either their bladder or their bowel in that situation, would be entirely unacceptable – not only from a patient dignity point of view, but form a medical complication. The issues related to infection relating to that – now, in situations in intensive care ... where people are actually sedated for long periods, then the issues of catheterisation or of using other collection techniques where someone is so deeply sedated are commonly used. So the issue here of simply being left to soil as normal practice I find astounding.

...

It's the whole treatment. The idea that you would leave someone – and I think it's commonly said, even in the early literature, the emphasis on not actually leaving people to soil but actually to assist them through mobility, through toileting, through other practices to avoid further medical complication is clear.

376 Professor Hickie did not think it mattered that Kylie sheets were used at Chelmsford for DST patients (I note this occurred after Dr Gill became a part owner in 1972 and that Kylie sheets

drew moisture away from the top of the sheet). Professor Hickie said he had assumed there would be some period of time in which the patients would be left in a soiled bed before they were attended to. He agreed that catheters should only be used when absolutely necessary because of the risk of infection. As I understood this evidence as a whole Professor Hickie's fundamental view was that sedating patients to the point where they were unable to be assisted to the toilet was itself an unacceptable practice.

377 Professor Hickie did not accept that when he referred in his report to "requirements" he meant "best practice". He said he meant "minimum standards" which he did not believe were time specific. When it was put to him that he had not practised in a private hospital he said:

...I think it's important to say a hospital is a hospital. Whether it has a private funding mechanism, a public funding mechanism, from the point of view of professional practice, is not relevant. The issue of professional practice is not dependent on whether you practise in the private sector or the public sector, as we define it in Australia.

...

There's no suggestion that people operating in the private sector – or in private hospitals in Australia are subject to less review or can undertake processes that are more risky or put their patients at greater risk than those who are practising in the public sector.

378 As to the operators of a hospital, he said:

The operators of a hospital – and this is very clear. The operators of a hospital – and whatever the arrangements are between the practitioners and the professional practice, it's not a matter of which company, whether that be a private company or New South Wales Health or other facility owns a hospital. It has got to do with the professional practices within that hospital and what are the oversight mechanisms and the responsibility. And very clearly, in medicine, this is transacted every day of the week, in the 1970s and now, of individual practitioners wishing to carry out certain activities within those facilities, and what is the oversight, so that individual doctors do not engage in activities that may place their patients at undue risk, without apparent oversight, without those issues being subject to continuous review by peers and by professional ... consistent with standards of practice, as one would expect for a profession that is engaged in these activities.

379 When it was put to him that in the 1970s there was no requirement for a medical practitioner to have oversight of a private hospital Professor Hickie said:

Again I – again I suggest to you it's irrelevant to say 'in the private hospital'. The issue is a practice issue. Practitioners in a private hospital are operating under the same ethical standards – and private hospitals, of which there are many excellent ones in Australia, operate with standards that are entirely equivalent and did in the 1970s with public hospitals, and they make a really important decision typically, which is not to undertake in their facility practices for which they do not have adequate facilities, staff, monitoring, reporting, so to not place people at undue risk. So typically many more complex or risky procedures in medicine are largely conducted in the public sector or



only in private hospitals that actually can meet the same standards. There is no difference in standards between the public and private sector for medical practice.

380 This exchange occurred:

Now, in relation to the private system, there was no requirement for there to be any medical superintendent or any doctor to oversee private hospitals. Can you please assume that for a moment. And the only – the only qualified person that was required for the conduct of a private hospital was a registered nurse. And what I’m suggesting to you is the people who are responsible for conducting themselves ethically within the private system were the doctors, including specialists, who admitted patients into that private hospital. Do you agree with that? --- No. The legal issue you describe is not the practice issue. I’m sure what you say legally – in terms of what person were legally required to do, but I’m saying that practice of – simply saying the practice only – or the practitioner only is responsible for what takes place in that facility wasn’t true in the 1970s and it isn’t true now. The legal – whether the legal requirements were different in the 1970s is a different issue. The issue of ethical practice of oversight by other practitioners within the facility and that the facility itself meet the standards of the day was true in the 1970s and is true now.

And what I’m suggesting to you is I could have owned a private hospital in 1970. Are you suggesting that a non-medical officer was somehow required, as the owner and operator of a private hospital in 1970, to supervise the conduct of specialists in the admission and care of their patients? --- You just made a key distinction between the owner and the operator. Does the operator have a responsibility? Yes.

I’m ? --- They had a responsibility in the 1970s ethically. They have a responsibility now. Now, what processes they use to ensure that has varied over time and ... but it’s clear that the operator – not the owner, the operator. Whoever is purporting to operate that facility, independent of the practitioners who actually conduct activities, in my view, had a clear ethical responsibility then and they do now, and this has been well looked at. There was no difference – to suggest it depended on whether you were in the public and private sector, I reject. The onus of the ethical responsibility for an operator, a hospital operator – the same.

...

Well, what I’m putting to you, Professor Hickie, is that there was absolutely zero requirement in the private hospital system in 1970 – in the 1970s for any supervision of the care and conduct and admission of patients by private practitioners into that hospital? --- No, I disagree with you again. Ethically, the operator of the hospital, whoever that may be, as far as I’m concerned, had an ethical obligation to provide a facility that was safe and met the standards of the day for the activity that was being conducted, whoever admitted those people. If you think about it in surgical terms or any other terms, you could admit a person to a hospital. If that hospital doesn’t meet infection control standards, if it doesn’t have appropriate recovery standards, if it doesn’t have appropriate ventilators or oxygen machine, that’s the responsibility of the operator, to provide the environment that is safe, including staffing levels, actually provision of adequate staff – that is the responsibility of the operator. That is not the responsibility of the practitioner who refers their patient to that hospital. That is different to the owner of the hospital, which may well be an independent company that has no expertise in such matters, and so typically, an owner would employ an operator, whoever that operator is, that meets the standards of the day in terms of professional practice.

And I want to suggest to you that under the relevant scheme, the operator, in the

relevant sense, being the supervisor of the nursing care and the other facilities in the hospital, was a nurse? --- Whoever is the operator of the hospital – and I – I would reject the notion in terms of being an operator – is ever going to be a single individual, since it's actually the staffing, the facilities, the infrastructure, the monitoring, the reporting, as we have in – in hospital standards, who oversees the quality control of services is never an individual, or it's certainly not a nurse who's overseeing the operations of the facility for the conduct of whatever the activity is that's planned. So typically, what you see in the private sector is a relationship between what activity and the risks associated and what level of staffing, infrastructure, facility is required to conduct that so that people can admit this – their patients to that hospital and expect it to meet the reasonable standards. It's not a legislative issue. It's actually a medical practice and ethical issue. The operator has a responsibility. Separately, they have a legal responsibility – they may have legal requirements of the day. But there are straight medical practice issues that are the responsibility of the operator.

So I think in the answer you have just given, you have referred to the facilities that are available in the hospital. Are you saying that when you're talking about the manager of a hospital as a general practitioner, that that person was ethically obliged to provide adequate facilities so that the specialist admitting had appropriate facilities in which to treat their patients. Is that what you're saying? --- Yes.

You're not suggesting, are you, that such a general practitioner was in a position to question the diagnosis that a psychiatrist made in relation to their private patient? If they – no. In fact, if they felt that they should, yes. Of course they could. Another doctor can question another doctor. It's not a matter of simply saying, because one is a psychiatrist and the other is a medical practitioner differently, that one is without question. One of the issues is, of course, if you are the operator of a hospital, whether you're – whatever the construct is, is the person being referred for the appropriate treatment suitable for that treatment? --- That's entirely something that should be also overseen independently of the practitioner. If you think of any medical procedure, you want to make sure that the people being admitted to the hospital – they are going to receive a treatment that is relevant to the problem that they have. And if that requires oversight, well, that is contestable or that needs to be reviewed by independent others, you would have processes in place to do that.

So your ? --- So this notion that an independent practitioner is just to admit people into private hospitals and no one ever did challenge them or ever was challenged, I would reject.

Well, Professor, are you seriously suggesting that the operator of a hospital needed to look behind every admission by individual doctors to determine whether or not that doctor had engaged in a proper diagnosis of the patient in relation to the treatment? -- - So most hospitals in these situations will require people to provide evidence that they are admitting people to their facility with the appropriate condition and for – in appropriate circumstances, be that surgical, be that medical, be that psychiatric in a particular way. And what is the evidence of that, that [the] appropriate person is coming for the appropriate treatment? Now, in this situation, that has to do with the indications for treatment. Why are people coming in to this hospital for this proposed treatment? So this issue that the independent practitioner can simply admit and do as they feel free to do or as they have done elsewhere, independent of the operator of the hospital, I would suggest is not true.

Well, I suggest to you, Professor Hickie, that it is quite ridiculous, in fact, to assert that a general practitioner would need to go behind every single admission by the many specialists admitting into the hospital that he operates or owns – as you have assumed, operates. That would be completely unreasonable and, in fact, was not the practice in

the 1970s? --- The way that you have described it, it's not a matter of going behind. It's a matter of documenting for what purpose the justification and for what treatment the person is actually being admitted to the hospital. And as – rather than say it's the responsibility of a general practitioner, it's the responsibility of the operator to make sure that their facilities are being used for the appropriate purpose. And that is what they have set the facilities up for, so there is a match between the patient need and what they can actually provide.

Well, I suggest to you that wasn't the practice in 1970 and it's not the practice now? - -- It is the practice now and it's an ongoing practice that these subjects are reviewed. So we have systems – and often in these days I would suggest they are better documented because of the ... systems that we now have – of who is being admitted. And they are continuously reviewed by, in fact, private hospital operators as they are. So it's not a matter of what you're asserting, that you check on every individual occasion. You are looking at the body of practice that is taken. Are the people being admitted to an appropriate facility? So you see this all the time, in fact, in private hospitals. If people are too complicated – it's too complex, it goes beyond what that hospital can provide, then many private hospital operators will say, 'No, we cannot deal with that level of complexity in our facility.' And they say to the operator – so it's very common for doctors, in fact, to admit to public and private hospitals or to private hospitals with different levels of services, relevant to their patient needs.

...

Well, Professor, I want to suggest to you that the opinions you just expressed in answer to that question, as to the manager of a hospital, are not supported by any literature available or applicable to the relevant time period? --- I don't accept that proposition, and if you have evidence of that, I would like to see it. I don't see the proposition you're putting as being at all consistent with my understanding of the operation of private hospitals over a long period in Australia, or in other private hospitals at the same time, or in terms of – I think you've referred to legislation as distinct from practice, in these particular areas.

Given you weren't, and have never, practiced in a private hospital in the 1970s or 1980s, what I'm suggesting to you is absent any review of relevant literature which sets out what the standards were at the time, you can't possibly and fairly express that opinion? --- I'm expressing the view on the basis of my knowledge of practice over a long period in the Australian health care sector, not having simply worked primarily in the public – private sector, does not mean that I'm not aware of continuously, the practice of my colleagues in both the public and the private sector, over this prolonged period, and including back into the 1970s.

And I want to suggest to you that not only was it not incumbent upon a general practitioner to question the diagnosis and treatment of a patient engaged in – by a specialist psychiatrist, it would have been quite improper for that practitioner to question a specialist, when that practitioner had no direct knowledge about the previous care or condition of that patient? --- No. As I said earlier, I reject that notion. I think any doctor with knowledge of the complications of putting – making a patient deeply unconscious, and in this setting, with limited capacity to monitor, would be able to – and would be expected. I actually would expect that any doctor would challenge any other doctor. This is not a matter of specialist and non-specialist. This is a situation all the time of respect for colleagues, of mutual respect and explanation, and often a reaching then of consensus, as to what are the appropriate conditions for what level of severity in relation to this facility, in relation to this treatment, can reasonably be undertaken.

... The hospital operator, I think, has a responsibility to know what treatments are being provided in its hospital and under what conditions and how will they be monitored. Is it reasonable or not to provide that in this facility in the first place? Now, many treatments are rejected on that basis. Somebody might want to do treatment X, and others will say, 'Not in my hospital.' Now, I don't see a sufficient argument for it. So that separation between the operator because of their ... their – it's not a matter of being a general practitioner or not. It's the operator. And the operator should, in my view, employ sufficient medical expertise, in house or independently, to reach that conclusion. Second of all, then, if you decide to go down – you can provide a treatment in a facility, if there are significant risks, and anything that involves this degree of unconsciousness over this particular period – any medical practitioner would understand there are significant risks, and given the background in terms of the literature of the range of mortality and morbidity, there are risks. An ... would be monitored, and the operator – the operator and those responsible for that operation, particularly those with medical expertise, would be expected to behave ethically, in a public hospital or a private hospital. This is not a time-dependent notion. It's that what was practice in the 1970s – you can see in private hospitals around Australia in terms of what they did in psychiatry, what they did in surgery, what they did in medicine – they had different levels of provision of care because often they could not provide the level of support that was required to actually monitor and evaluate different levels of risk and care. Then the people who admit to those hospitals also have a responsibility to ensure that they are bringing patients to facilities where those patients will be treated in the most appropriate and safest fashion. So typically, operators in many of these areas, in many areas of medicine, including psychiatry, would admit – and to this day, would admit different patients to the public sector, where there may be greater facilities and greater oversee by nursing and other staff or greater other aspects of provision of physical treatments, including complicated pharmacotherapy, versus private hospitals.

382 I do not accept that any of the applicants' criticisms of the evidence of Professor Hickie have merit. From his evidence it is apparent that none of the matters on which the applicants relied undermine the fundamentals of Professor Hickie's opinions. It is immaterial that Professor Hickie was not admitted as a psychiatrist until 1984. He had knowledge of the history of psychiatry and in particular of the history of narcosis therapy. It is immaterial that Professor Hickie had not practised in a private hospital. He had knowledge of the Australian hospital system as a whole and did not accept the distinction in standards the applicants sought to draw between public and private hospitals. Nor did he accept that the legislative regime for managing private hospitals in the 1970s determined acceptable practices at the time. Professor Hickie did not accept that he needed to conduct a literature review to express the opinions he gave. I agree with this view. Professor Hickie's expertise and particular interest in sleep/wake cycles and the history of psychiatry in dealing with the issue meant that he was well qualified to give the opinions he did. I do not accept that Professor Hickie's opinions were not based on his specialised knowledge. They manifestly were based on his highly specialised knowledge about the history of psychiatry in respect of sleep/wake cycles.

- 383 The applicants' submission that Professor Hickie's opinions were baseless because of his lack of personal expertise in relation to private hospitals and psychiatric practice in the 1960s and 1970s entirely overlooks the sound foundations of his evidence – his particular expertise in the history of psychiatry in respect of sleep/wake cycles.
- 384 The applicants' submission that Professor Hickie referred to ethical protocols at hospitals in the 1970s that had not been produced misunderstands the effects of his evidence that there were long-standing standards of acceptable management of vulnerable people which became a focal point for ethical conduct after abuses in psychiatry including in the Second World War and in the Soviet Union.
- 385 The applicants' submission that having not done a literature review Professor Hickie merely assumed that no conditions were indicated for DST involves a misrepresentation of the effect of his evidence. Professor Hickie considered that there were no indications for DST by the 1960s because of the manifest risks associated with the procedure when other safer and demonstrably more effective treatments had become available. He relied on the whole of his expertise to express this view. It did not matter that he had not done a literature search for the purpose of his report. Further, no literature was put to him suggesting his opinion might change if he had reviewed the literature.
- 386 Professor Hickie's evidence was not heavily influenced by the details in the schedule under the heading "Treatment". It was clear that his primary assumption about DST was correct – that its basic object was using barbiturates for deep sedation over the best part of each 24 hour period. His evidence was primarily based on his expert knowledge of the history and risks associated with coma-based therapies and the alternative treatments which had become available from the 1960s onwards. Professor Hickie did not refuse to make assumptions inconsistent with the schedule. The evidence to which the applicants refer is to do with ECT where Professor Hickie's basic point was that there was no evidence of the absence of complications from unmodified ECT at Chelmsford and if the ECT was inducing a seizure (which it was) it was necessary to use a muscle relaxant. The fact is no assumptions inconsistent with the schedule were put to Professor Hickie. Accordingly, I reject the applicants' submission that Professor Hickie doggedly adhered to the schedule and was thus incapable of being an independent witness.
- 387 Further, the fact is patients were left to soil their beds. Professor Hickie was right that there must have been some period of time before each patient who had soiled the bed had their sheets

changed. Even if the period was brief because nurses or nurses' aides were continuously monitoring the patients (which the evidence does not suggest was the case) it does not change the fact that DST caused many patients to be incontinent most of the time as they were incapable of being roused sufficiently to be assisted to a commode. The applicants have missed Professor Hickie's basic point that there was no justification for sedation of this kind for psychiatric illnesses by the 1960s.

388 Professor Hickie did not need to have worked in a private hospital to give evidence about the Australian hospital system as a whole. He was making the valid point that the legislation relating to private hospitals and their funding is one thing; the way in which those hospitals operated in practice as part of the overall health system in Australia was another. Nor was the thrust of Professor Hickie's evidence about the obligations of the operator of a private hospital in any way absurd. It makes perfect sense for the system to involve the operators of private hospitals ensuring they made appropriate decisions about the kinds of treatment the hospital could responsibly offer. It is difficult to see how any private hospital could function at all but for the existence of such a responsibility. If the operators required medical expertise to fulfil this responsibility then it was a matter for the operator to ensure such expertise was to hand, as Professor Hickie said. It was not self-evidently ludicrous for Professor Hickie to give evidence that a person in the position of an operator who had medical expertise should have ensured that DST was not permitted to be carried out at Chelmsford. This does not mean that the operator had to go behind every diagnosis for every patient admitted to Chelmsford. It means that the operator was responsible for ensuring that treatments offered at Chelmsford could be safely provided in the environment of Chelmsford. Professor Hickie was not alone in reaching the conclusion that DST could not be safely provided at Chelmsford. All of the relevant experts expressed the same conclusion.

389 I found Professor Hickie's evidence cogent and persuasive. I accept his evidence including that by the 1960s coma-based therapies (of which DST was one) could only be considered as experimental and well beyond the scope of normal psychiatric practice. By the 1960s there was no indication which justified the administration of DST in any setting outside that of a clinical experiment (with the associated requirements of such a setting). As such, a clinician (be it a psychiatrist or general physician) providing DST at Chelmsford in the 1960s and 1970s was negligent, unethical and engaged in medical malpractice. A manager of a hospital at that time with medical expertise would also be negligent, unethical and engaged in medical malpractice by permitting DST to be administered outside of the setting of a clinical experiment.

## 6.7 Professor Patrick McGorry

390 Professor McGorry has been practising as a clinical, research and academic psychiatrist in Australia since approximately 1986. He graduated in medicine in 1977.

391 Professor McGorry prepared an affidavit in which he said:

In the circles in which I mix, including other psychiatrists and other medical professionals, Dr Herron and Dr Gill have a reputation as doctors who in conjunction with Dr Bailey practiced the discredited and dangerous practice of DST at the infamous Chelmsford Private Hospital ... which led to serious injuries and even deaths of many patients. They have a reputation as doctors who seriously damaged not only the health of their patients, but also the standing of psychiatry within Australia, augmenting the worst fears of the community and adding to stigma and fear. Their reputation was permanently damaged within the psychiatric community because of their association with Chelmsford.

...

It is also notorious within the psychiatric community in Australia that the practise of DST at Chelmsford, including by Dr Herron and Dr Gill, involved the mistreatment of vulnerable patients by the provision of a dangerous, non-evidence-based treatment, being DST. Dr Gill and Dr Herron are therefore considered, in the circles in which I mix, including other psychiatrists and other medical professionals, as practitioners who totally failed to fulfil their ethical obligations to the patients under their care.

...

The behaviour of the Applicants at Chelmsford is part of a deeply shameful aspect of the history of psychiatry. In my view, and that of the psychiatric community generally, the first principle of ethical medical practice, dating back to the time of Hippocrates, is to 'first do no harm'. This has been repeatedly ignored by a significant body of psychiatric practice throughout history, which history brings great shame to the psychiatric community. The history of such practice is chronicled in a classic book by Eliot Valenstein entitled "Great and Desperate Cures" in which dangerous treatments such as leucotomy are featured. This pattern of unethical practice derives from a relative dearth of effective treatments in previous eras and a lack of commitment to research-guided, evidence-based clinical practice. In the circles in which I mix, the practice of DST at Chelmsford was another chapter in this saga of unethical psychiatric practices, and accordingly the reputation of those that practised that treatment is of persons that are unethical and have brought great shame to the profession. This is particularly so as the scandal at Chelmsford occurred in the modern era, where there was even less excuse for this behaviour, than during the period prior to discovery of modern psychiatric treatments.

392 In his oral evidence Professor McGorry explained that the "modern era" was the period from the 1950s to 1960s when new psychiatric treatments began to appear. By this he meant in particular the new psychotropic drugs that became available from this time onwards - antipsychotics, antidepressants, mood stabilisers, anti-anxiety drugs – which were developed and used significantly in the 1960s. He acknowledged these drugs had side effects and further advances had been made in the 1980s and 1990s including new drug classes. New behavioural

therapies were also developed and became common in the 1960s and 1970s. But the big drug breakthroughs were made in the 1950s and 1960s founding the modern era in psychiatry.

393 Professor McGorry explained that there were different levels of evidence including:

...what we call Cochrane Level 1 evidence, which means that it's supported by multiple randomised control trial evidence captured or integrated through meta-analysis or systematic reviews. That's the kind of gold standard. So if you have that level of evidence, then everyone will be very comfortable about that – those sorts of treatments being offered. But you know, a lot of conditions in medicine and psychiatry, it's very difficult to assemble evidence of that quality, partly – well, rare conditions, for example, or where you know I suppose the ethical challenges will make it difficult to do an ECT. And also you know, psychiatric research in particular hasn't been as well-supported as say, cancer research. So not all of the research has actually been done. So in the meantime, you have to treat patients with the best knowledge, the best available evidence, which might not reach that sort of pinnacle of quality. So then there are other levels of evidence you're probably aware of, and there are probably about five different levels of evidence that Cochrane and the MRC would grade scientific evidence as, with the lowest level being you know, expert consensus, you know where conditions don't really have an awful lot of evidence, apart from their clinical experience and what they agree is the best approach with a particular problem. So it's a gradient, so I suppose medically accepted practice would mean it's like a dimensional thing. You know, practices can be accepted you know, much more strongly if they have got the highest level of evidence, and less accepted and probably much more room for disagreement when it comes down to the lower levels of evidence.

394 He considered that certain treatments were based on the highest level of evidence being:

...antipsychotic medication for psychosis, antidepressants for depression, and cognitive behaviour would have been another one emerging. So – but ECT, there were randomised control trials of ECT, as well. So yes, psychosurgery, absolutely not.

395 He said that for ECT:

...the evidence was actually fairly compelling that as long as you used it for very narrow indications such as life-threatening depression in the elderly, there was pretty good evidence to support it. And there was certainly some randomised control trials where sham ECT has been compared with real ECT, and it's quite convincing actually.

396 However, in the 1960s and 1970s ECT was being used for “a wider spectrum of conditions than it should have been used, according to the evidence”.

397 Professor McGorry did not accept that merely because a practice was widespread it was acceptable. If it was sufficiently widespread the practice might pass the level of evidence of expert consensus. He considered reference in textbooks to treatment could be relevant but they were usually a few years out of date. Similarly, journal articles could indicate the state of the art but their quality was mixed. He accepted that other psychiatrists could be role models but a person had to use judgment about which role model to follow even in the 1960s and 1970s. He



would not necessarily accept that someone considered eminent would be an appropriate role model.

398 Professor McGorry agreed that the procedure of leucotomy had been carried out in Australia into the 1980s and said “it still may be possible to perform these sort of operations under very extreme circumstances”. He acknowledged some psychiatrists considered the treatment justified at the time but he did not as he saw no benefit from the procedure.

399 Professor McGorry had read psychiatric texts from the 1960s and earlier but had not seen any reference to prolonged narcosis in those texts and was unaware of other articles published about the practice. He said that by the time he was in practice such therapies had been so discredited that there was no reason to consider them. He said articles had to be read with a critical mind as from the 1920s to 1970s many articles had lots of methodological problems; just because something was published did not mean it was correct or a sound basis for practice. He said he had only read about narcosis therapy recently and that he understood that:

...people were sedated with barbiturates and other tranquillisers for long periods of time. And I’m not even clear what the rationale for how they thought it might work actually is. Or why – why – you know, I can’t even understand the theory behind it, but I know what they did. And I think perhaps the dangers of that should have been appreciated – but that’s what I – I think even at the time I think, you know, a reasonable doctor – medical doctor should have really understood what the physical risks of such a treatment might be.

...

Well, that’s the first principle of, you know, medicine. First do no harm, isn’t it. So you basically have to think of that very, very carefully. And every decision you make about treatment should be informed by risk benefit considerations. Absolutely.

400 Professor McGorry accepted that a psychiatric textbook from 1973 (Sainsbury MJ, *Key to Psychiatry: A Textbook for Students* (Australia and New Zealand Book Co Pty Ltd, 1973) (***Key to Psychiatry***)) did not condemn narcosis therapies even though it said that the treatment had few advocates as it had been largely overtaken by other forms of treatment. He said he was a medical student at the time and “didn’t care what was in a textbook” and made his own mind up about treatments such as leucotomies. He explained:

...So you’ve got to use your own judgment here. Just because it was written in a textbook – you’re not a robot, you’re not a child in a primary school, you’ve actually got to think. You’re a medical specialist. So I can see what you’re saying, and I’m actually a bit shocked to see the deep sleep therapy in a textbook as late as this, without any warnings. But I’m equally shocked, perhaps even more shocked to see the leucotomy was still there, in this way, and you really do have to think for yourself. That’s the other way, that’s the other side of this point.

401 Professor McGorry did not accept that he was a standout for critical thinking, saying:

Well, maybe I was a little bit different. But you know, I was training in Newcastle, I wasn't training in Harvard, or you know, Columbia University. I was just a normal person, and it seemed pretty obvious to me as a human being that some of these practices – and I did think ECT fell into that category before I actually saw it in practice – were pretty barbaric. And I sort of still have that opinion about the deep sleep therapy and the leucotomy. ECT has got a small place, as I say, based on evidence of the fact that it does actually work and it's pretty safe. But the other two practices are just, you know, extreme.

402 He accepted, however, that the Sainsbury textbook gave the impression that prolonged narcosis was an accepted practice in 1973. He was not aware of the use of sleep therapy in Britain and Australia from the 1950s to the 1970s. He was taken to Rubinstein WD and Rubinstein HL's *Menders of the Mind* at 172 which said that:

Deep sleep therapy was regarded as a risky but nevertheless medically acceptable technique which had been widely used internationally and was referred to in psychiatric textbooks as recently as 1972.

403 Professor McGorry said that the same text described these therapies as “abuses” (at 172) and he himself considered DST an abuse. I note that the same text also said that Dr Bailey's practice of DST at Chelmsford did not involve adequate safeguards to limit mortality. He said:

You've got to actually have a scientific and a Hippocratic approach. First do no harm. And I think that's what was lacking at Chelmsford. And in relation to the persistence of deep sleep therapy and probably insulin coma therapy and certainly leucotomy – well beyond dates when it was pretty obvious they were much harmful than beneficial.

404 Having seen the literature described above from the 1970s he said:

But the literature is rubbish, you know. The literature from that time, as you can see from the sort of studies that have been quoted here, is largely rubbish.

405 He said in the modern era (that is, after the 1950s) psychiatrists should have been more critical and should have observed the harm that was occurring to patients from unproven therapies. He explained:

...it goes right back to the first, 'do no harm' principle. So if haven't got really good scientific evidence to justify it, then the risk/benefit ratio has to be the key thing that you weigh up in that situation. And, you know, I can quote Sir William Osler, who's the father of medicine, a professor of Oxford – Professor of Medicine at Oxford at the turn of the 19th to 20th century, you know. So he said the duty of the doctor is: *To cure sometimes, to relieve often, and to comfort always.*

And that's what you do with people who – who actually have intractable or severe conditions. You don't expose them to – to risk or harmful and desperate cures like these people did.

406 Professor McGorry said he had heard of all three names of Dr Bailey, Dr Herron and Dr Gill in relation to DST at Chelmsford. He said younger doctors would not necessarily know who they were. He said, however, that the subject of DST at Chelmsford had certainly come up in his training but he had not been involved in education and training more recently so did not know if it was still front and centre.

407 Professor McGorry said that Sainsbury's *Key to Psychiatry* described narcosis therapy as having the patient asleep for about 20 of 24 hours and that it seemed the patient would be woken for meals and other nursing procedures. He gave this evidence:

If the case is that in Chelmsford, the patients were not roused for meals, but they would simply lay in bed in a barbiturate-induced sleep with a Ryles tube up their nose into their stomach, do you understand that what Dr Sainsbury here, says here is conferring approval on – not on rousing the patient for meals, but for keeping them comatose for the 24 hours, and feeding them through a Ryles tube. Do you understand Dr Sainsbury is approving that practice? --- It doesn't look like it, but yes.

And is it – it's only very, there was a very general reference at the – in page 320 there, about – well, I withdraw that. You see the words: *Among the sedatives used are amylobarbitone, [chloropromazine] and paraldehyde*. There's nothing there, is there, about the amounts of those drugs that – to be administered, and how often they're administered? --- Yes.

There's no advice there, is there, about different kinds of – I withdraw that. Yes, and then if you go a bit further down that page, do you see that charts and records of temperature, blood pressure, respiration, urinalysis and fluid balance has to be kept. Do you see that? --- Yes, yes, I do. Yes, yes, yes.

So if it was the case that at Chelmsford, among other departures, there was no record kept of urinalysis and fluid balance, in that this is the style of DST practice at Chelmsford. Would you understand Professor Sainsbury to be, or Dr Sainsbury to be approving of DST that didn't include charts and records of urinalysis and fluid balance? --- I don't think he – he doesn't seem to be approving of that. No, because he is saying that we should – he said must be kept, so he was emphasising the 'must.'

Yes, and then if you go back to page – the very first page, and the introduction by – the foreword by William Barclay, the very first page. Do you see the third paragraph, where Dr Barclay says: *The book is directed primarily to nurses, to students of psychiatry...*

Sorry. Yes? *Nurses Primarily to nurses, but students of psychiatry, no matter what their discipline, will find this book a valuable introduction to their subject.*

Does that tell you something about what, and for whom, this book was intended? --- Well, yes. If the title of the book is 'Textbook for students,' that would probably imply medical students, but in this case, it's even – perhaps not even at that level, it's more like nursing students. But you know, it's sort of implying that there's some value, would be some valuable information for more specialised, and maybe – but it doesn't seem to be directed at psychiatrists in training, for example, or psychiatrists, from my reading of the foreword and the title, actually, now that you mention that.

Yes? --- So it's a pretty low-level textbook, I would say.

Yes, and if I can just take you back to page 309? --- And actually, there's a chapter here called, 'The nurse as a person.' So it does look like it's directed at nurses, rather than anyone – anybody else.

Yes, yes. So therefore, not directed at practicing and qualified psychiatrists, and members of the college who are contemplating using narcosis therapy? --- No, I would not have thought so.

408 This evidence was also given in relation to Elliot S Valenstein's *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness* (Basic Books, 1986) (*Great and Desperate Cures*) at 294:

And Ms Chrysanthou took you to a passage at the end of that page where the author said 'my personal view' – or:

I do not believe, as many well-meaning people have suggested, that there [are] any scientific or ethical principles that will enable us to make the necessary predictions and decisions.

Well, I just want to ask you in case it's not clear. Is it your view that the principle of 'do no harm' is such a scientific – or at least ethical principle? --- Yeah, that's the number 1.

409 The applicants accepted that Professor McGorry was an honest witness who was trying to assist the Court.

## **7. SLEEP THERAPY AND DST**

### **7.1 Applicants' submissions**

410 The applicants' submissions, particularly those dealing with the effect of the evidence about DST, are especially problematic. They involve a series of propositions said to be based on parts of the evidence which, on analysis, represent a highly selective and tendentious view of the effect of the evidence. It is impossible to deal with every distortion of the evidence in the applicants' submissions but it is necessary to explain my wholesale rejection of the applicants' propositions about DST.

### **7.2 Psychiatry**

411 The applicants posit that in the 1960s and 1970s psychiatrists used controversial therapies that would be condemned now and in their desperation to help patients relied on literature and the experiences of others in pursuing treatments.

412 The applicants submitted that the conduct of the doctors involved in DST has to be judged by reference to the standards at the time and the respondents had failed to do so.

413 This distorts the effect of the expert evidence. The expert evidence made clear that the first principle of medical practice was at all times to do no harm. While abuses in psychiatry had occurred, the advent of the modern era of psychiatry, which was from the 1950s and 1960s, offered new treatments which were safer and more effective than treatments previously available. These alternatives made narcosis or coma-based therapies, which had always been known to be high risk, outmoded by the 1960s. By that time I accept that there was no justification for narcosis or coma-based therapies because of the known risks and the lack of proven benefits. Any use of such therapies, including DST, would be considered experimental from the 1960s onwards, and to meet acceptable standards at the time needed to have been conducted according to the standards applicable to clinical experiments. DST as administered at Chelmsford, at the time it was conducted, departed so far from acceptable standards at the time that it should properly be characterised as negligent, unethical and medical malpractice. That was the effect of the expert evidence and no criticism that the applicants made of the experts undermined the validity of their fundamental opinions to this effect. These opinions were not reached by reference to the standards applicable today. The experts reached these views having regard to the standards they said were in place at the time that DST was being administered. As the summary above discloses, this point was made repeatedly by the experts and cannot be disregarded merely because the experts did not all do what the applicants assert was necessary, in particular carry out a literature search on the efficacy of DST. The applicants have not established that this was necessary for the experts to give their evidence and express their opinions. Nor was it necessary for the experts to have “expertise in hospital administration” to express their opinions. They all had extensive involvement in the hospital system in Australia and were well able to give evidence about the acceptable operation of that system at the time DST was being administered at Chelmsford.

414 It is not the case that the experts were giving evidence about their own idiosyncratic experiences of hospital management. They were familiar with hospital management systems and were able to give evidence about acceptable and unacceptable practices at a systemic level. The assertion that those who gave such evidence did not have the specialised knowledge to do so is irreconcilable with the experience of the experts.

415 The applicants posited that consent procedures were “loose” in the 1960s and 1970s and there was no proved requirement to get written consent for DST or ECT at the time. While Dr Phillips used the word “loose” to describe consent requirements in the 1960s and 1970s, the weight of the evidence, including that of Dr Phillips, was to the contrary of the applicants’ submissions.

Dr Smith believed it was a legal requirement to obtain informed written consent to place a patient into a coma. Professor Parker believed written consent was required for the level of sedation involved in DST. He recalled that “as a junior doctor, in the mid-60s, any procedure that we did, we needed people to sign a consent form.” Dr Phillips described DST as an experimental procedure, which thus required fully informed consent. He said that given the idiosyncratic and experimental nature of DST there was a need at the time to ensure the patient gave a properly informed consent. Professor Hickie considered that the standards at the time required clear evidence of the written and informed consent of each patient to the full nature and extent, including the likely risk, of exposure to DST. He said that in terms of the practice of medicine the standards involved in the requirement to obtain written consent had not changed, irrespective of changing legislative requirements. I accept this evidence.

416 The applicants submitted that a “treatment was medically acceptable if there was evidence that it was widely used, or if referred to as a treatment in contemporary psychiatric textbooks, or if it was the subject of papers in reputable medical journals”. The evidence of the experts was to the contrary. The first principle remained to do no harm. The mere reference to a treatment in a book or article was not a sufficient basis to adopt it (particularly not a treatment involving the rate of death and complications of narcosis therapies). A psychiatrist or medical practitioner had to bring to bear a critical mind. As Professor Hickie said, with respect to the obligation to do no harm, particularly in the context of dealing with vulnerable people, “[i]t’s not simply a matter of what is written down at a particular point, these are continuing ethical principles.” He said these principles had a long history and were not invented in the 1980s and 1990s. As Professor Parker said psychiatry was not an “evidence free zone” in the 1960s and 1970s, yet DST was practised at Chelmsford irrespective of the lack of any credible scientific evidence of its benefits and in the face of evidence of the serious harm it involved (including the deaths of patients throughout the period of its administration at Chelmsford – as to which see below).

417 The effect of Professor McGorry’s evidence was not that psychiatry had involved practices that would now be considered disgraceful abuses but were not so considered at the time. The effect of his evidence was that there had been disgraceful abuses which should have (and in his case were) considered disgraceful abuses at the time.

418 Nor was it the effect of Professor McGorry’s evidence that the publication of an article in a reputable medical journal was a guarantee of quality. To the contrary, he considered many publications up to the 1970s to be methodologically flawed and was of the view that everything

had to be read with a critical mind and no one should base their practice on one or two articles. The whole body of available evidence would have to be considered. Professor Hickie also did not say a reasonable medical practitioner could rely on an article to determine whether or not they should use a treatment. He was far more circumspect, saying that an article may be a factor that informed a decision about practice but:

...it's not necessarily sufficient. It may inform, and for many treatments actually simply reading about or knowing that a treatment may be effective doesn't mean you necessarily are able to provide that treatment safely or appropriately in your own setting.

419 The expert evidence was not to the effect that a psychiatrist “picking up a textbook by an eminent psychiatrist could reasonably rely on that text in determining how and when to use a treatment”. Professor McGorry’s evidence in that regard was confined to the list of indications for ECT. Dr Phillips was referring to relying on DSM (the Diagnostic and Statistical Manual of Mental Disorders). They were not suggesting that merely because coma-based therapies appeared in books and articles any psychiatrist or general practitioner could rely on that reference to justify treating patients with DST. The experts all held a contrary view to this. They knew that coma-based therapies appeared in books and articles (if not articles as late as the early 1970s) but were firmly of the view that by the 1960s and 1970s there was no justification for such treatments which, by that time, had to be considered experimental.

420 The fact that the applicants bore no onus of proof is immaterial. The expert evidence the respondents adduced was all to the same effect – by the 1960s DST was an outmoded and highly risky procedure for which there was no justification outside the setting of clinical experiments given the alternative treatments which were by then available. There were no competing expert opinions.

### **7.3 History and use of deep sleep therapy**

421 The fact that the applicants conducted their own literature search and tendered articles dealing with coma-based or narcosis therapies is immaterial. They never suggested to any of the experts that the literature meant that they should change their opinion about DST. It is by no means apparent that the therapy referred to in the articles bears any resemblance to DST as administered at Chelmsford (and in the case of Dr Sargant at least, the evidence is overwhelmingly to the effect that the therapy was different). There is also evidence that articles published up to the 1970s contain many methodological flaws. Further, there was no expert evidence called by the applicants to suggest that the articles should lead to contrary views to

those reached by the experts the respondents called. Moreover, the criteria by which the articles were selected is unknown, as are the criteria by which articles were excluded. In these circumstances, it may be asked, why would I place any weight on the articles? The fact that they were published, and some in reputable medical journals, does not mean that the expert evidence in this case – that by the 1960s narcosis or coma-based therapies had no justification other than as part of clinical experiments – is incorrect. Indeed, what is apparent is that the articles involve the experimental use of these therapies and, as the experts made clear, also disclosed the high level of risks these therapies involved. What is further apparent is that despite the no doubt best attempts by the applicants they have been unable to find any article about even the experimental use of such therapies after 1974. DST continued to be administered at Chelmsford until 1979.

422 Most of the articles referred to by the applicants pre-date the modern era of psychiatry (which began after the 1950s). It is not clear to me why I would give any weight to articles which concerned experiments with narcosis therapies before the 1960s and the advent at that time of new drugs which had proven effectiveness and safety (albeit not without side effects). Articles post-dating the modern era are few in number and bear no resemblance to DST and are plainly experimental in nature. The 1968 paper “Dauerschlaf” in Archives of General Psychiatry by Ernest Hartmann (“**Dauerschlaf**”) involved a mere four patients being subjected to narcosis over three to four days. This says nothing about the propriety of DST as administered at Chelmsford. The work of Dr H Spencer Bloch in 1970 detailed in “Brief Sleep Treatment with Chlorpromazine” (1970) Compr Psychiatry (11)4 (“**Brief Sleep Treatment**”) at p 346 involved 114 patients being sedated for up to 72 hours. Again, this has nothing to do with DST as administered at Chelmsford. The work of Dr Sargant, which as I have said the evidence makes clear was not the same as DST, continued until 1974 but Dr Sargant (unlike the doctors at Chelmsford) was involved in publication of his methods and results (in other words, his treatments were conducted on an experimental basis). And on the evidence, Dr Sargant was himself a controversial figure in psychiatry, not unlike Dr Bailey himself.

423 The texts on which the applicants relied also disclosed that narcosis therapy had largely been abandoned throughout the world by the 1960s, no doubt due to the availability of alternative efficacious and safe treatments by that time. The evidence about Sainsbury’s *Key to Psychiatry* from 1973 is not to the effect the applicants propose. The text provides no support for DST as practised at Chelmsford. The text is directed at student nurses, not medical practitioners.



- 424 Valenstein's *Great and Desperate Cures* published in 1986, as its title suggests, is about the extremes of psychiatry, largely before the modern era.
- 425 The reference in the oral evidence to LG Kiloh, GF Johnson and Dr Smith in *Physical Treatments in Psychiatry* (Blackwell Scientific Publications, 1988) recording that a form of sleep therapy (unspecified in the applicants' submissions and unidentifiable given the publication is not in evidence) "is still used in the occasional psychiatric clinic" does not involve any suggestion that what was being used bore any resemblance to DST.
- 426 Similarly, the fact (if it be a fact) that in 1991 there was a report in Victoria about the use of narcosis or sleep therapy in that State on a large number of patients, allegedly in the thousands, is of no assistance to the applicants. The report is not in evidence. It is not known when that therapy was being administered. Nor is the nature of the therapy apparent.
- 427 The references in the 1996 publication *Menders of the Mind* to Chelmsford and Dr Bailey is also of no assistance. It refers to deep sleep as a well-known but "infrequently used, form of therapy dating back to the 1920s" (at p 168). That publication notes that the therapy was used in England by Dr Dax (but it is unclear when) and in Melbourne at the Larundel Hospital in Bundoora in the 1950s (on the cusp of the modern era in psychiatry). It said that (as was discussed in the Royal Commission report, Vol 3 at p 18) Dr Sinclair used a form of sleep therapy in Melbourne until the late 1970s. The form of therapy used by Dr Sinclair is unknown and in circumstances where it is apparent that the notion of sleep therapy extended from short-term light sedation to long-term induction of coma as in DST. The same publication also said that Dr Bailey used none of the safeguards necessary to limit mortality (at p 168), and refers to Dr Bailey and others being guilty of malpractice (at p 169). The publication also queries why the RANZCP (Royal Australian and New Zealand College of Psychiatrists) did not act earlier and concludes that most senior members of the RANZCP did not know the details of DST at Chelmsford until the late 1970s (at pp 170 to 174). This is contrary to the applicants' proposition that many medical practitioners knew about DST and did not publicly condemn it at the time (although, as the evidence above, shows, some did as soon as they understood what DST involved). If a publication is in for one purpose it is in for all purposes including the lack of knowledge of senior members of the RANZCP about the details of DST at Chelmsford until the late 1970s. The publication, in any event, by no means suggests that DST as administered at Chelmsford was an appropriate therapy. The publication also refers to a memorandum from 1980 by the RANZCP's Psychotropic Drugs Committee which stated that DST was

“undoubtedly a hazardous technique” and that there was presently “no justification for this form of treatment” (cited at p 171). This is a near contemporaneous opinion of an expert panel (noting that DST only ceased at Chelmsford in 1979) to the same effect as the whole of the respondents’ expert evidence in the present case. It lends weight to that expert evidence.

428 The *Menders of the Mind* publication does state that DST was “regarded as a risky but nevertheless medically acceptable technique which had been widely used internationally and was referred to in psychiatric textbooks as recently as 1972” (at p 172). However, a number of points must be made about this reference. First, it appears in the same paragraph as a sentence describing “the abuses at Chelmsford”. It is unlikely that the authors meant that the abuses involving DST at Chelmsford were a medically accepted technique. Second, it is apparent that “deep sleep”, “sedation therapy”, “narcosis therapy” and “coma-based therapy” cover a wide range of practices. There is no evidence that DST as practised at Chelmsford was the same as or even relevantly similar to the therapies which had been reported on since the 1920s. Third, the fact that one reference could be found to deep sleep in a 1972 textbook hardly suggests that by that time it was a medically acceptable technique. The unmistakable scarcity of references to the therapy after 1970, in fact, support the unanimous opinions of the experts in the present case that by the 1960s there was no justification for such a risky procedure.

429 Chapter 6 of Shorter’s publication *History of Psychiatry* (1997) covers the history of sleep therapy but has its history ending by no later than 1967. The applicants noted that the “history as described in Shorter was clearly missing the significant use of sleep therapy by Sargant, and Harry Bailey”. The publication in fact lends support to the conclusion that the so-called therapy had moved far outside of accepted practice by the 1960s. As also noted, Dr Sargant’s stated aims and reported results confirm that his therapy was not equivalent to DST at Chelmsford. And as noted above, on the evidence Dr Sargant was himself a controversial figure in psychiatry, not unlike Dr Bailey. In any event, the fact that a (very) few practitioners of a form of sleep therapy can be found from the early 1970s tends to confirm the opinion of the experts in this case. The willingness of (very) few practitioners in the world to continue with a form of sleep therapy in the 1970s (not a form necessarily bearing any resemblance to DST at Chelmsford) does not undermine the expert evidence in this case that the therapy had become outmoded and was by the 1960s unjustifiable in any circumstance (other than in the setting of clinical experiments) given its high risks and the availability by that time of alternative treatment regimes.

430 As a result of this analysis I reject or qualify the applicants' submissions as follows:

- (1) *sleep therapy or narcosis was being used around the world in different forms from the 1920s until the 1970s*: the weight of the evidence is that sleep therapy was widely recognised to be outmoded, dangerous and unjustifiable by the 1960s. The fact that a few practitioners in the world continued with forms of the therapy (not equivalent to DST) into the early 1970s merely highlights the fact that the broad consensus had resulted in the use of the therapy being otherwise generally terminated;
- (2) *DST was a medically acceptable treatment in the 1950s, 1960s and 1970s*: the weight of the evidence is that sleep therapy was not generally accepted to be a medically acceptable treatment by the 1960s and 1970s. The evidence is also that DST as practised at Chelmsford was never a medically accepted treatment because of the high risks involved in such deep sedation over lengthy periods and the inadequate nature of systems at Chelmsford to ensure the safety of patients undergoing DST;
- (3) *empirical research was undertaken as to the safety and efficacy of the treatment*: the therapy was always reported to involve a high level of risk of death and serious complications. Further, the quality of the research between the 1920s and 1970s is dubious. I would not accept any of the research as a reliable indicator of the safety or efficacy of sleep therapy. Nor can the results of that research be taken as relevant to DST as practised at Chelmsford where no research appears to have been undertaken as to safety or efficacy in contrast to the work of, for example, Dr Sargant;
- (4) *each paper footnotes a series of other papers on the treatment, indicating that significant research and reporting has been undertaken in relation to sleep therapy around the world*: it is obvious that the research into sleep therapy waned after the 1950s which is to be expected given the introduction of modern drug therapies from that time;
- (5) *different drugs were used to induce sleep and included chlorpromazine, barbiturates, bromide and insulin*: this may be accepted but there is no evidence of any research or other example involving the approach to DST at Chelmsford. As Professor Parker said, this involved a standard cocktail of multiple drugs prescribed to each patient by way of a procrustean pro-forma treatment sheet the inferred objective of which must have been to render patients effectively comatose continuously for lengthy periods;

- (6) *the period of sleep varied from 12-24 hours with different levels of wakefulness reported*: there is no report of a treatment which equates to DST at Chelmsford in terms of the polypharmacy used and what must be inferred to have been its intended effects (long-term deep sedation over effectively each period of 24 hours);
- (7) *the medications were generally administered by nurses who had discretion as to the dose and timing of medication*: there is no suggestion that the research involved a setting such as Chelmsford where no doctor was on duty continuously and no medical observations were recorded by doctors in the patient notes and where I would not infer from the evidence that the doctors attending the patients in fact examined the notes made by nurses;
- (8) *patients were monitored by nurses in quiet wards (generally no visitors) and observations and nursing care were regularly attended to*: it is not apparent from the research that there were “generally” no visitors. The level of sedation involved in the reports varied widely and was not the same as DST at Chelmsford;
- (9) *a wide range of ailments were indicated for sleep therapy*: as noted above, the interest in sleep therapy had waned after the 1950s. By the 1960s there was no indication that justified DST;
- (10) *nasogastric feeding was used by some and not by others*: this may be accepted (albeit not in Dr Sargant’s version of sleep therapy) although it is not apparent that such feeding was undertaken for the length of time that DST at Chelmsford frequently involved (weeks, not mere days);
- (11) *sleep therapy was often combined with ECT and was sometimes administered to a patient who would not otherwise tolerate a course of ECT*: this may be accepted but there is no suggestion that ECT was administered without an anaesthetic, muscle relaxants, and oxygen;
- (12) *catheters were generally avoided unless necessary because of risk of infection*: this may be so but it is not apparent that the research routinely involved patients who were sedated to the level of incontinence as was the case with DST at Chelmsford;
- (13) *complications arose which included pyrexia, pulmonary embolus, pneumonia and bowel and abdomen problems*: the other main complication reported included death. All of these complications were well known with any form of narcosis therapy;

- (14) *raised temperatures were common and usually resolved*: it is not apparent that any analysis has been undertaken enabling the conclusion that raised temperatures were usually resolved;
- (15) *by the 1950s the treatment had a mortality rate of about 1%*: if all adequate safeguards were taken this reported mortality rate for narcosis therapy (not DST) may be accepted but, if all safeguards were not taken, the mortality rate increased to 2 to 5%. As noted above, according to *Menders of the Mind* at 168, DST at Chelmsford involved none of the required safeguards. This is also apparent from the evidence as a whole;
- (16) *different practitioners over different times adopted different methods using narcosis or deep sleep*: this may be accepted but there is no evidence that any other practitioner used a regime equivalent to DST as practised at Chelmsford; and
- (17) *patients were not kept in intensive care units (which were not introduced in NSW until the 1970s)*: intensive beds were available long before the 1970s. The research papers are precisely that – reports on sleep therapy as an experimental procedure involving published observations and reports. Nothing similar occurred at Chelmsford.

431 I also accept the respondents' criticisms of the applicants' approach of attempting to rely on selected articles to support the supposed safety and efficacy of DST. As noted, the criteria for selection and exclusion of the articles are unknown. It is also not suggested that Mr Herron or Dr Gill were relying on these articles (or knew of them) when administering DST. There is no capacity to review the methodology used in or results reported in the articles. The articles describe various forms of narcosis therapy, but not DST. The applicants' Table A, which attempts to compare the treatment in the articles with DST, has 16 entries, 11 of which are from the 1950s or earlier. Of the remainder, three are articles by Dr Sargant. Two are articles describing a form of treatment which bears no resemblance to DST. One (Bloch's "Brief Sleep Treatment", 1970) referred to abbreviated therapy of 24 to 48 hours to minimise the (known) incidence of respiratory complications. The other (Hartmann's "Dauerschlaf", 1972 at p 99) said that:

In the United States, sleep therapy has been little used in the past 20 years, due in part to occasional reports of cardiovascular problems and bronchopneumonia, but due chiefly to the increasingly widespread use of tranquilizers such as the phenothiazines in acute psychosis.

(Citations omitted).

432 As the respondents submitted, this is consistent with the expert evidence in this case and inconsistent with the applicants' propositions about DST in the 1960s and 1970s. As the respondents put it:

All of this demonstrates the correctness of the view held by the experts in these proceedings: by the 1960s, narcosis (however described) was an outmoded treatment.

433 The applicants' attempts to prove that (contrary to his own statements) Dr Sargant's treatment involved DST are unconvincing. Professor Whyte's evidence does not support the applicants' proposition. As the respondents submitted, the applicants' proposition:

- (1) "is contrary to what is described in the Sargant article [Modified Narcosis ] where Dr Sargant refers to the sedation as 'light' (APP256, p 655, first column) and describes his patients being awake to eat (APP256, p 655, second column). The Applicants cannot rely on Sargant to show that the treatment is reputable, but in the same breath say that his article contained falsehoods"; and
- (2) "is also contrary to Dr Bailey's statement to the Podio Inquest about how his treatment compared to Dr Sargant's (HN000A, p 64):

There are, however, marked distinctions in our methods of treatment. He has never maintained the levels of deep sedation that I have over the same number of years."

434 As to the applicants' criticisms of the experts called by the respondents for not doing (or not doing more extensive) literature searches, as the respondents put it:

The Respondents' experts provided the views that they did. They were (and are) eminent figures in their respective fields, with deep experience in their fields. Had a different expert come along and provided different views, based on a literature search, then there would be a legitimate dispute between experts. That is not the case. The experts speak with one voice and lack of more detailed review of the various historical articles referred to by the Applicants does not detract from their analysis.

435 For the reasons given above I reject outright the applicants' submission that:

By the time Dr Bailey started using DST in the 1950s it was not an experimental treatment. It was soundly empirically evidence-based as established in the sample of literature set out above which Dr Bailey confirmed by visiting each treatment centre using DST around the world. By the time that Dr Bailey started using DST at Chelmsford in 1963 he himself had an established treatment method. He was not 'trialling a new intervention' (Hickie T1572.9) he was merely slightly modifying an existing one, depending on his experience using the intervention on many patients.

436 To the contrary, by the time Dr Bailey began treating patients with DST at Chelmsford in 1963 he was engaged in a dangerously outmoded therapy for which there was no justification given the alternatives then available. There is no justification for the conclusion that Dr Bailey was

merely slightly modifying the practices of others. It is simply not apparent that DST as practised at Chelmsford was being used anywhere else in the world. DST was Dr Bailey's own invention and in that sense was experimental. It was not, however, conducted as an experimental treatment as conditions at Chelmsford met none of the minimum requirements Professor Hickie identified as necessary for the conduct of experimental treatments at the time.

437 I do not accept that "given the extent of the use of the treatment reported, including the successful outcomes, it [DST] was considered an accepted treatment in the 1960s and 1970s". The fact that very few practitioners (including Dr Bailey and the applicants) were still using some form of sleep therapy in the 1970s in different parts of the world, if anything, confirms that by that time the therapy was so far out of the mainstream it could not be classed as an "accepted treatment". Dr Phillips plainly did not consider DST an acceptable form of treatment. He did not consider DST bore any resemblance to Dr Sargent's work.

438 I agree with the respondents' submission that the applicants' repeated proposition that Dr Bailey followed Dr Sargent's work must be rejected. None of the experts accepted this proposition. The applicants called no expert evidence to support the proposition. As the respondents pointed out from Dr Sargent's own descriptions critical differences are apparent:

- (1) in Dr Sargent's treatment, "patients would sit up and take their meals at the bed and there 'has never been need' to use a tube to fee[d] patients. At Chelmsford, that is precisely what occurred: patients were fed a mixture of sustagen and egg through a Ryles tube"; and
- (2) in Dr Sargent's treatment, "patients walked (with nursing assistance) to meals and to the toilet to ensure vital exercise. At Chelmsford, patients did not get that exercise: they were supine, being fed through the nose and (generally) wetting their bed rather than having exercise by getting up to go to the toilet".

439 Based on the expert evidence and the numerous Chelmsford patient files I have examined I accept that the aim of DST was for patients to be sedated to a point where they could be said to be mostly in an induced coma for a period of about 14 days. I do not accept Mr Herron's evidence in this proceeding that the goal was a level of sedation from which the patient could be aroused but not completely woken. This is inconsistent with all of the expert evidence and irreconcilable with the evidence of the nursing notes. While many patients were rousable and became restless or awake at the end of the time period for the administration of the drugs the basic aim was for them to be continuously deeply asleep. The fact that patients became rousable

and restless near the end of the four hourly dosing period, and that some were occasionally capable of being assisted to the toilet, does not mean that they were not generally comatose during DST. The observations of the nurses on which the applicants relied are not sufficient to displace the effect of the expert evidence as to the level of sedation which would be achieved by the polypharmacy involved in DST. In any event, I do not accept that nurses were qualified to assess sedation levels based on what appear to be mere general observations of the rousability of patients at the end of the four hourly drug administration period. The nurses may have considered that they were qualified to do what they were doing (they would hardly have done it otherwise) but the expert evidence is all to the same effect – there was no safe level of care which could be given to DST patients at Chelmsford given the risks involved. Accordingly, the nurses’ views that the nursing was excellent and competent are beside the point. There was nothing the nurses could have done to make DST a sufficiently safe procedure for it to be appropriately conducted at Chelmsford. The fact that the nurses were “experienced, professional, diligent and careful and cared for their patients to the best of their ability” may be accepted. But it in no way undermines the effect of the expert evidence that DST was such a dangerous procedure it could not be safely administered at Chelmsford or, indeed, in any setting other than as part of a clinical experiment conducted as such (and subject to stringent safeguards as explained by Professor Hickie and none of which were in effect at Chelmsford).

440 For the same reasons it does not matter that, as the applicants stressed:

- (1) there was always a registered nurse responsible for the sedation ward who made decisions about the patient’s care, including the administration of any drugs (as noted, the nurses were not qualified for this responsibility);
- (2) nursing aides and assistants were always present, with at least one in the sedation ward at all times (an exaggeration because, in fact, at least one was in the entrance to the sedation ward at all times rather than being in the ward itself);
- (3) the patients were constantly monitored and checked by the nurses (another exaggeration based on the evidence – a nurse was always in hearing distance of the patients but the patients were not being continuously monitored);
- (4) observations for each patient were taken and recorded at least every four hours and more frequently if necessary including pulse, respiration, blood pressure and temperature (which ignores the problem that the nurses could not be expected to always know when more frequent observations were necessary);



- (5) nurses observed the patient to decide how much medication to administer and when to administer it, albeit in accordance with the ranges specified on the standardised treatment sheets (to the contrary, on the evidence, some nurses routinely prescribed the maximum dose at the minimum time and others exercised their discretion to the extent it was available given the pro-forma treatment sheet. The discretion was not one any nurse should ever have had as the evidence is that a skilled anaesthetist could not have safely managed the complex polypharmacy involved in DST);
- (6) patients were nursed in ripple beds on their sides with their heads positioned to maintain a clear airway and were naked to enable full observations to be maintained (however, the evidence of numerous patients having compromised airways during DST is overwhelming);
- (7) patients were moved from side to side every two hours and were given passive limb exercises and chest percussion when necessary (in fact, it is not apparent from the evidence that these treatments were routine);
- (8) fluid intake for each patient was carefully measured and output monitored by the nurses in so far as times that urine was passed or bowels were opened (fluid output could not in fact be monitored);
- (9) any unusual smelling or coloured urine was noted and tested by the nurses or sent to pathology to be tested;
- (10) catheters were not used because of the high risk of infection, and patients were immediately changed when wet which is a safer procedure, and the literature at the time suggested that urinary catheters should only be used when absolutely necessary because of danger of infection, and patients were not left to lie in their own faeces or urine (sheets were changed when the nurses noticed the patients had soiled themselves. I am unable to accept that this always occurred immediately on soiling);
- (11) suction machines were used to clear mucous secretions of the nose and throat which would normally be swallowed or expectorated by a conscious patient (which was plainly inadequate to prevent respiratory complications); and
- (12) there was a detailed oral handover between nurses on changing shifts.

441 Even if the nursing always reached the standard asserted by the applicants at all times (which is doubtful given the vagaries of human nature) it does not change the fact that by the 1960s and 1970s there was no justification for exposing patients to the risks involved in DST. No

level of nursing care could effectively eliminate those risks and certainly not care provided in a small private hospital without a doctor on continuous duty (and I infer from the evidence that a specialist anaesthetist would have been required) and having immediate access to the kind of intensivist equipment Professor Whyte identified.

442 As the respondents submitted, each of the relevant experts concluded that DST was a treatment that should not have been practised in the 1960s and 1970s. None of the cross-examination made any impact on the force or validity of this conclusion by each of the experts. For the reasons given above I accept the respondents' submissions to the following effect:

- (1) the applicants' contention that the use of DST as practised at Chelmsford was justified because some forms of prolonged narcosis and sedation therapy were referred to and used by other practitioners must be rejected as irreconcilable with the weight of the evidence;
- (2) the applicants called no expert evidence seeking to defend the use of DST or to opine that the journal articles and texts on which the applicants relied justified the use of DST at Chelmsford;
- (3) it is not apparent that the therapies described in the literature tendered by the applicants was the same as or sufficiently similar to DST as administered at Chelmsford to enable any rational inference to be drawn from that material about the acceptability of DST at Chelmsford; and
- (4) the only literature which Mr Herron said he had read while involved in administering DST was that of Dr Sargant whose treatment was manifestly different from DST (no tube feeding, patients able to take meals at their bedsides, and patients able to walk to meals and toilets).

443 As the respondents noted, Mr Herron agreed that DST was extremely dangerous. He accepted that pulmonary embolus was a well-known complication for sedation therapy and the chances of such an embolus were higher because DST required patients to be lying down for significant periods. These risks were well known and should have been obvious at the time to any medical practitioner. I accept the respondents' submission that "DST conducted at Chelmsford was extremely dangerous, without any proven benefit".

444 The respondents submitted that:

Those who were employed as nurses at Chelmsford did the best that they could in the

circumstances. However, they were placed in an impossible position by reason of the complete abdication of responsibility by the treating doctors.

445 I agree. The evidence is clear. There was no doctor (let alone an anaesthetist) on continuous duty at Chelmsford. The nurses managed the administration of medications in accordance with a pro-forma treatment sheet involving complex polypharmacy. They did so based on mere external observations without any knowledge of concentrations of drugs accumulating in the patient. They were trying to do safely what a qualified anaesthetist with access to intensivist equipment most probably could not have managed. As the respondents noted:

There was no doctor on hand at the hospital. Nurses were expected to carry out their task, call the responsible doctor if they needed or, if it were an emergency, call Dr Gill (who lived 10-20 minutes away).

...

Most importantly, nurses were required to make decisions about the amount and timing of sedation. The means by which this was done was particularly unclear. Although the evidence shows the use of terms such as being 'lightly' or 'deeply' sedated, the meaning of that, in a medical sense, is entirely unclear. There was evidence that different nurses took different approaches to how 'deep' the patient should be. But whatever the language meant, it was entirely inappropriate for nurses to be making those decisions.

446 None of this accords with the required setting, arrangements and equipment the experts said would have been necessary at the time to ensure that DST could be safely provided (assuming that there was any justification for using it as a treatment at the time which the evidence made clear there was not).

447 Having regard to these matters I must reject the applicants' submission that:

The equipment at [Chelmsford] was fit for the purpose of treating and caring for the sedation patients. No witness could identify any emergency situation in which they found that the equipment was lacking.

448 The fact that the nurses could not identify any situation in which the equipment was lacking does not mean it was fit for purpose. It must also not be overlooked that the nurses were incapable of resuscitating John Adams. It was only the fortuitous intervention of a doctor, who happened to be at Chelmsford, which prevented his death on the floor of the DST ward. As it was, he died a week later after his transfer to Hornsby Hospital.

449 I also must reject the applicants' submission that:

Dr Herron, the only expert called in hospital administration was of the view that the facilities at CPH were appropriate for the treatment of sedation patients and the nursing staff were adequately trained to carry out the care for those patients under his supervision.

450 I do not accept that Dr (as he was) Herron was an expert in hospital administration. His views as expressed above may be honestly held but they do not in any way undermine the force or validity of the expert evidence that in administering DST to patients at Chelmsford Dr (as he was) Herron was engaged in negligence, unethical conduct and medical malpractice.

451 I do not accept the applicants' submissions that because the experts were not provided with copies of all records maintained in respect of patients (but only the patient file) that somehow negates the effect of their evidence. It may be accepted that the documents maintained at Chelmsford and elsewhere included the following:

- (a) patient register;
- (b) admission record with personal details and consent signature;
- (c) nurses notes, including 4 hour chart, 12 hour chart and drug charts and pathology records;
- (d) drug register (kept in drug cupboard) where drugs were signed for;
- (e) Bailey book – where Dr Bailey (and Herron) wrote directions (including prescriptions) for patients and where a record was kept of patient ECTs;
- (f) Day/Night reports – where a 24 hour record was kept of every patient in the hospital;
- (g) nurses' message book – a record of communications regarding administrative matters;
- (h) doctors' clinical notes – not kept at the hospital, but at the doctors' private rooms, which included referral letters;
- (i) running sheets of observations kept in the sedation ward;
- (j) Chelmsford book kept at 187 Macquarie St with details of all treatments given to Dr Bailey's patients at CPH as reported daily by the Matron or Sister to Jan Allan;
- (k) Dr Bailey's appointment books at 187 Macquarie St;
- (l) Cards of data of patients from CPH prepared and kept by Dr Bailey;
- (m) Dr Herron's order book.

452 However, what is telling is that the applicants did not put a single additional document to the experts to suggest that the opinions they had reached about DST were invalid. Further, there is no evidence of the doctors' clinical notes forming any part of a continuous record of their care of the patients. Moreover, the hospital file comprised the nurses' notes, the observation charts and pathology results. The evidence supports the inference that this is the only continuous record of patient care at Chelmsford. As such, it may properly be inferred that this record contained all information relevant to the patient's care whilst at Chelmsford. As I have said,

the applicants did not put to the experts a single additional document which they said should have caused the expert to change their opinion about any matter concerning DST. And no such document has been identified in the applicants' submissions. In these circumstances, the applicants' criticisms of the experts' evidence on the basis that they were not briefed with all relevant documents cannot be given any weight. As the respondents noted:

...The available Chelmsford file for every patient was provided to each expert. Those records alone were enough to establish that the patients received DST, the delivery of which each expert agreed was grossly outside standard medical practice at that time. No other records are necessary for the experts to properly form that opinion.

...

If the Applicants considered that further records were available which could have affected each experts' opinion, then they could have put such documents to the experts and had them make whatever concessions flow from that. That is the nature of litigation. The Applicants' approach is to speak in generalities about missing documents without any demonstration that any document was both available and would have made any difference to the experts' opinion. That approach should be rejected.

453 I do not accept any suggestion that the fact that Chelmsford was subject to annual inspections and renewal of its yearly licence by the Health Commission of New South Wales should lead to different conclusions from those I have reached. If the inspections were by medical practitioners (which is not apparent), and they knew the details of DST, then the only conclusion open on the evidence is that those medical practitioners from the Health Commission were in gross dereliction of their duty by not taking steps to ensure that the administration of DST at Chelmsford ceased. The negligence of others does not excuse the applicants.

454 The applicants noted that a Senior Pharmacist of the Poisons Branch of the Health Commission carried out a detailed inspection in 1971. Further:

On 20 October 1971, the Poisons Branch recommended that a written standard drug regime be provided to the [Chelmsford] staff where a patient is to undergo 'narcotherapy': APP 55, 92. The written standard drug regime the Poisons Branch recommended for 'narcotherapy' was in the form Dr Bailey and Dr Herron adopted for their patients: see APP55 p204. Dr Bailey maintained this system until DST ended in 1979: APP 131.

455 It is not apparent what qualifications a Senior Pharmacist would have held. The fact that the Poisons Branch of the Health Commission did not recommend the immediate cessation of DST did not justify its continuation given the evidence which I have otherwise accepted.

456 The applicants submitted that “the Health Commission expressly or tacitly approved the standardised DST treatment administered at [Chelmsford] throughout the 1970’s.” This may be so but the potential gross negligence of a government department (if it did indeed tacitly approve of DST) does not excuse the gross negligence of two specialists (Dr Bailey and Mr Herron) and one general practitioner (Dr Gill, as to whom see below) involved in the administration of DST at Chelmsford.

457 For the reasons discussed above, I have no difficulty in characterising the conduct of Dr Bailey and Mr Herron and Dr Gill as gross negligence. I agree with the respondents that the term means something more than mere negligence but the difference is one of degree: *DIF III – Global Co-Investment Fund LP v Babcock & Brown International Pty Limited* [2019] NSWSC 527 at [306]-[307]. I do not accept that the concept of gross negligence involves the elements of the crime of manslaughter. Administering a highly dangerous and outmoded treatment to patients for which there was no justification at the time in the setting of Chelmsford was grossly negligent, unethical and involved medical malpractice. The treatment should never have been administered at all at Chelmsford in the 1960s and 1970s. Nor should any ECT have been administered in conjunction with such a dangerous treatment, let alone administered on many occasions by Mr Herron (and Dr Gardiner) without the use of an anaesthetic, muscle relaxant and oxygen. Mr Herron’s explanation for not giving a muscle relaxant was as follows:

My clinical judgment was not to give a relaxant unless there was risk of a severe convulsion to give damage to the body and this was indicated by the level of sedation. I was concerned that the risk from the effect of the relaxant on breathing was too great given the reduced risk using the Glissando machine.

458 The inescapable fact is that the Glissando machine induced a seizure. The expert evidence was clear. If ECT is used to induce a seizure (which is the sole purpose of ECT) then there is a risk of injury to the patient if a muscle relaxant is not used. No expert considered the fact of sedation a sufficient justification for not using a muscle relaxant. Nor does the evidence indicate that oxygen was routinely administered as part of ECT when this was a standard requirement at the time. The evidence also persuades me that a number of patients experienced serious pain during ECT while under DST as a result of not being anaesthetised which was medically and ethically unacceptable.

459 I agree with the respondents that the applicants’ submission that the respondents needed to prove that patients were harmed by their subjection to DST before the applicants’ conduct can be characterised as grossly negligent should not be accepted. As the respondents put it:

The ordinary reasonable reader is not attuned to the specific elements of the cause of action of negligence in tort. Subjecting a patient to a treatment that is extremely dangerous and without any therapeutic value, with a very high risk of death, is something that any ordinary reasonable reader, or indeed a lawyer, would regard as grossly negligent.

...

It is normal English usage, as well as normal legal usage, to characterise such conduct as 'negligent', or 'grossly negligent', whether or not the conduct has been the subject of successful legal proceedings.

460 In any event, patients were seriously harmed by DST and ECT as administered at Chelmsford. Some suffered ongoing trauma and memory loss. Some became very ill during DST such as Mr Hart. Others died.

461 The applicants' apparent reliance on the "eminence" of Dr Bailey as somehow justifying their conduct is also unconvincing. Mr Herron was a specialist psychiatrist of a number of years standing. Dr Gill was a general practitioner with the power to decide what treatments could be provided at Chelmsford (even if that power was one to be exercised in consultation with his fellow part owners). They were not entitled to suspend their independent medical judgment merely because Dr Bailey was a well-known psychiatrist and an apparently charismatic figure. From their medical knowledge they must have known that DST was highly dangerous and by the 1960s and 1970s was well outside the bounds of mainstream psychiatric practices. Similarly, the fact that certain other doctors (such as those doctors consulted when DST patients developed serious complications as not infrequently occurred) must be taken to have known what DST involved yet did not take steps to stop it does not excuse the applicants from responsibility for their conduct. Other doctors (such as Dr Smith and Dr Phillips) knew about DST and did try to take steps to have it stopped at the time. A failure at the time by some in the medical profession, who were not directly involved in administering the treatment but must have understood what it involved, to recognise that what was occurring was unacceptable, negligent, unethical and involved medical malpractice and their associated failure to take steps to stop what was happening at Chelmsford does not justify or excuse the actions of those medical practitioners who were in fact perpetrating the treatment on their vulnerable patients.

462 Mr Herron's extraordinarily cavalier attitude to the use of DST despite its known risks is exposed by the fact that he subjected children to the treatment. The applicants have not sought to explain how it could have been thought appropriate by Mr Herron to render a child unconscious for an extended period through the use of barbiturates. As the respondents submitted:

One example is Ms Tweedale, who was 14 years old when she was treated at Chelmsford: MED00086.14 (RTB7). The only evidence of the reasons that she was admitted to Chelmsford were:

- (a) In December 1976, because she had overdosed on Valium: MED00086.11 (RTB7)
- (b) in March 1977 because she ‘is very depressed’ and having some difficulties with the school that she was in: MED00086.44 (RTB7).

...In addition to this, at the adolescent age of 14, Ms Tweedale’s personality and behaviour repertoire were still in the process of formation: EXP00013.7 (RTB1).

...None of these matters were sufficient to warrant such drastic treatment and Ms Tweedale later developed significant psychiatric damage based on her treatment at Chelmsford.

...Similar to Ms Tweedale, Ms Wales was 13 years old at the time of her treatment at Chelmsford: MED00055.1 (RTB6). Following the reasoning of Professor Philips [Dr Phillips] in respect of Ms Tweedale (EXP00013.7 (RTB1)), given her adolescent age, there was no justification for Ms Wales’ admission to an adult psychiatric hospital for such a treatment.

(Footnotes omitted).

463 The applicants’ submissions to the contrary involve an attempted defence of the indefensible. The fact that Ms Tweedale’s father, an anaesthetist, consented to her treatment at Chelmsford does not remove the fundamental obligation Mr Herron had to do no harm. How he could have thought that subjecting a child to this dangerous unproven treatment was appropriate is not apparent.

464 Nor does Dr Bailey’s apparent enthusiasm for his treatment and apparent genuine belief in its benefits excuse the applicants. Unlike the other research papers with published results, there is nothing but anecdotal evidence about perceived levels of successful treatment by DST. Medical practitioners, as was clear from the expert evidence, had an obligation to bring their own critical judgment to bear upon a procedure which had manifestly high risks of serious harm and death. I reject outright the applicants’ submission as follows:

Dr Bailey is not alive to defend himself and he was similarly not alive to respond to the allegations made at the RC [Royal Commission]. The Court should not readily infer, given the material available to it, that Dr Bailey was anything other than a diligent and careful and extremely intelligent and skilled doctor. Memories fade, relevant evidence becomes lost, and over the years suspicions and rumours about Dr Bailey progressed to belief to reconstruction to recollection to assumed fact by the RC. This court should be cautious to ensure that adverse inferences about Dr Bailey are not drawn based on inexact proofs, indefinite testimony, or indirect inferences.

465 The submission is irreconcilable with all of the expert evidence. By the 1960s a person in Dr Bailey’s position should have known that he was perpetrating on vulnerable people an



experimental treatment based on an outmoded form of therapy which involved a high risk of serious complications and death when other much safer alternatives were available. He should have known that what he was doing fundamentally contradicted the first principle of medical practice to do no harm. The expert evidence speaks with one voice – it is not a matter of inexact proofs, indefinite testimony, or indirect inferences. The depths of Dr Bailey’s disgraceful conduct could not be more plain from the expert evidence which I accept, namely:

- (1) at the time there was no indication for the drug regime used in DST at Chelmsford;
- (2) a simple risk-benefit assessment would indicate DST involved a very high risk of serious, potentially life-threatening, adverse effects with minimal or no benefits;
- (3) the use of prolonged narcosis was effectively abandoned throughout the world by the late 1950s because it was found to be an ineffective but highly dangerous treatment and because the introduction of major and minor tranquilisers and antidepressant drugs allowed for the more appropriate treatment of patients with little risk of death or serious side effects (the validity of this conclusion is not contradicted by the fact that the applicants were able to identify a very few doctors in the world who were still experimenting with narcosis therapies in the 1960s and 1970s);
- (4) DST has never been established empirically as a valid treatment for specific psychiatric conditions or as a non-specific modality having benefit across a range of psychiatric conditions;
- (5) DST involved complex polypharmacy which would have been difficult to manage even by a skilled anaesthetist, let alone nurses basing their responses on mere observations;
- (6) the practice of DST was not based on any acceptable scientific rationale which existed at the time and had no justification. It was an idiosyncratic and experimental treatment placing the patients at such a high risk of harm that they could only be looked after in an intensive care unit or intensive care bed (before such units were available). Each patient who was treated with DST at Chelmsford was managed in a non-acceptable/callous/reckless manner, with treatment placing each patient at risk for immediate complications, and adverse long-term consequences;
- (7) the availability of alternative treatments with much lower risks of harm and much greater evidence of benefit by the mid to late 1960s meant that a professional and ethically-based approach required the cessation of all coma-based therapies. From the

mid-1960s onwards any further development of coma based therapies could only be considered as experimental and well beyond the scope of normal practice; and

- (8) a reasonable medical doctor should have readily understood what the physical risks of such a treatment might be. It was obvious DST was much more harmful than beneficial and it conflicted with the first principle of medical practice to do no harm.

466 The applicants' reliance on the hearsay evidence of Dr Bailey, as the respondents submitted, is inherently problematic. He created DST and might be expected to be its most staunch defender. As the respondents submitted (and as I conclude):

- (1) Dr Bailey asserted that DST patients were put to bed in a "special ward where intensive care facilities exist" (HN000A, p 55): this was untrue. Chelmsford plainly did not have intensive care facilities commensurate with those in existence at the time, as the expert evidence discloses;
- (2) Dr Bailey asserted that he had a practice of explaining DST to patients in his rooms (HN000A, p 65): it is profoundly unlikely that Dr Bailey explained to patients the serious risks involved in DST including serious long-term complications and death. The evidence from his patients is also to the contrary;
- (3) Dr Bailey states that DST had a "success rate" of 85% (HN000A, p 54): there is no evidence supporting this assertion. As the respondents submitted:

The lack of any expert from the Applicants seeking to prove DST's efficacy or therapeutic benefit, or at least, defend its use is a further indicator of the complete emptiness of Dr Bailey's statements about his 'success rate'. In contrast to the patients who came before the Court to describe the traumas of the treatment, there was no patient before the Court describing any of the supposed 'success' of the treatment;

- (4) Dr Bailey told the inquest into the death of Ronald Carter in 1967 that he routinely examined the DST patients (including their heart and lungs) on his rounds at Chelmsford (HN000A, Annex I, p 41): this was contradicted by evidence from nurses;
- (5) Dr Bailey told the Ronald Carter inquest that DST was "used fairly universally" by psychiatrists (HN000A, Annex I, p 54)]. When asked about whether his technique was the "recognised technique", Dr Bailey said it was "widely used" (HN000A, Annex I, p 55): this was untrue, being contrary to the expert evidence and the applicants' literature searches; and
- (6) "At the Ronald Carter inquest, Dr Bailey agreed that [a] dose of Amylobarbitone between 2 and 3 grams per 24 hours could be lethal (HN000A, Annex I, p 25). When

faced with the fact that he had prescribed such an amount (2.4g) to his own patient, he said that such a dosage would be safe and not capable of being lethal (HN000A, Annex I, pp 67-68).”

467 I accept the respondents’ submission that:

For all these reasons, the Court should treat with extreme scepticism any evidence contained in the Hearsay Notice of Dr Bailey which is not verified from other sources. In particular, the suggestion that DST had a ‘success’ rate of 85% should be entirely rejected: there is no such evidence other than Dr Bailey’s assertion.

468 I consider the evidence of former patients of Chelmsford who underwent DST and their relatives discloses that the treatment involved a most serious form of abuse of vulnerable persons. Even if the patient had been fully informed of the nature of the treatment (which, despite the self-serving evidence of the applicants and Dr Bailey to that effect, is inherently unlikely as the patients would have had to be informed in clear terms of a real risk of serious long-term harm and death), nothing could have prepared them for the trauma that the evidence indicates DST inflicted on many patients. The fact that the recollections are those of former patients who may be accepted to have been suffering from some psychological distress or psychiatric disorder which prompted them to seek treatment does not mean that their recollections of trauma are unreliable. Nor do inaccuracies about details undermine the thrust of their evidence that they were subjected to something deeply dehumanising and terrifying, which warrants the description of abuse.

469 As the respondents submitted, the evidence includes the following:

- (1) many patients have distressing memories of being shackled to the bed;
- (2) patients recall naso-gastric tubes being inserted, choking as liquid was passed through it, and being in such discomfort as to try and tear the tube out;
- (3) patients recall being semi-conscious while given ECT with feelings including burning hot metal being placed on their temples, feelings of dying with a patient’s mind and body going into a great painful darkness, being held down while begging and screaming for the electricity to stop;
- (4) patients were aware of being in the DST ward but were unable to move or speak, hearing moaning and screaming from other patients, seeing bodies strapped in beds around them as if in a morgue, experiencing foul and putrid smells, and while partially sedated saw other patients being subjected to ECT;

- (5) lightening out of DST caused patients to suffer serious hallucinations. One patient recalled hallucinating people with their arms cut off and blood spurting across the room. Another hallucinated rats crawling across the room and her children being taken away from her in wagons. Patients emerged from DST confused, distressed, disoriented and weak, sometimes unable to walk or bathe without assistance and some having suffered severe weight loss. Some patients experienced convulsions and seizures on lightening out of deep sedation. Some patients felt trapped or imprisoned during their recovery from DST believing (wrongly) that they were locked into Chelmsford; and
- (6) many patients reported continuing problems after DST including long and short-term memory loss, changes in personality, anxiety, depression, respiratory issues, sleeping issues, learning difficulties and migraines. Some patients felt the treatment took away part of their life and is something they have spent their lives struggling to overcome.

470 Many patients suffered complications during DST (unsurprisingly given its risks). According to the medical records (as opposed to the anecdotal recollections of nurses) they suffered pneumonia and respiratory distress, bedsores, high temperatures, cyanosis, breathing difficulties, vomiting, aspiration of dark stomach fluid, distended abdomens and bladders, and serious blood pressure issues.

471 As the respondents submitted:

...the sheer volume and variety of complaints from patients and loved ones demonstrates that this cannot just be a put down to side-effects which were known and accepted by patients. Rather, it was part and parcel of the mistreatment of patients which occurred in the DST ward at Chelmsford. DST was not only dangerous, it was dehumanising. It was appalling that patients were subjected to its horrors, particularly considering the complete lack of objective evidence as to any benefits.

472 I also accept the respondents' submission that the lengthy submissions of the applicants rejecting the credibility of Mr Finn, Ms CW, Ms GW and Ms CO because their evidence does not accord with the contemporaneous documents is unrealistic and unconvincing. The substance of their evidence is consistent with much of the evidence about DST and how it was administered at Chelmsford – involving a highly dangerous and terrifying ordeal for the patients.

473 I agree with the respondents that the approach taken by the applicants to the evidence in their submissions is problematic. The approach is highly selective and has the effect of distorting the overall effect of the evidence. The respondents pointed to a number of examples (which I accept as follows):

- (a) At AS Sched 1, [223] the Applicants submit that Dr Herron gave instructions that for his patients, nurses were instructed to medicate while the patient was awake, and that those instructions were complied with. That submission is based on the evidence of Nurse Beattie alone. It is contrary to Nurse Beattie's own evidence that medication was administered via the Ryles Tube (Beattie pg. 64 (CB4 HN0011)). It is contrary to the evidence from a number of other nurses that medication was administered via the Ryles Tube. To the extent it is suggested that Dr Herron gave specific instructions for his own patients it is also contrary to the other nurses' evidence. Indeed, Mr Herron's affidavit refers to the goal of sedation therapy being to get the patient to a level where they can be aroused but not completely woken (Herron 2, [43]). There is no mention in the affidavit of patients waking up for medication.
- (b) At AS Sched 1, [304], the Applicants rely on evidence of Mr Herron that patients' calves were squeezed every morning. There is no evidence of this from nurses.
- (c) At AS Sched 1, [286]-[293], the Applicants seek to suggest that the treatment provided by William Sargent was an equivalently 'deep' level of sedation to that at Chelmsford. That ignores the evidence of the creator of DST at Chelmsford, Dr Bailey ... (HN000A, p64).
- (d) In a similar vein, the Applicants would have the Court conclude that the patients were not in a deep level of coma (AS, Sched 1, [225]). Again, that case is not consistent with Dr Bailey's evidence to the Podio inquest (HN000A, p51):

For the treatment to be effective the patients had to be kept at deep levels of sedation or coma for sufficiently long periods of time.

- (e) The Applicants say that Mr Herron's practice was not to pre-sign treatment sheets (AS, Sched 1, [204]), but neglect to refer to his own evidence that he did pre-sign treatment sheets (T2635.15-2637.15), or the example of the pre-signed treatment sheet that is in evidence (MED00180, RTB9).

(Footnotes omitted).

474 I agree also with the respondents that the problem with the applicants' submissions extends to propositions that are not supported by the evidence at all. The respondents pointed to the following:

- (a) At AS Sched 5, [88], the Applicants seek to make something of evidence from Ms Bothman at the Royal Commission about the number of patients in the sedation ward. Her actual evidence was that after the Audrey Francis inquest, the numbers increased: Bothman, [27] (AFF001, pg. 7). That is borne out by the Bailey Book to which the Applicants refer (APP232). There were between one and three patients in the sedation ward between 11 August and 2 September 1976. This can be compared to the full state of the sedation ward in November 1976.
- (b) At AS Sched 1, [355], the Applicants say that Ms Bothman admitted that Dr Gill was in an 'impossible position' when she raised issues with him, because he couldn't interfere in Dr Herron or Dr Bailey's treatment of their patients. That does not take account of Ms Bothman's evidence at T1298.10-18. That evidence was to the effect that there was no point raising matters with Dr Gill

in respect of the specific treatment of particular patients, but her concerns about the ‘the sedation and what was happening in there, and the risk of what could happen’ were appropriate to raise with Dr Gill.

475 The cavalier approach of Mr Herron to the notion that patients should give informed consent to treatment (and which supports my inference that no patient was given the information they needed to give informed consent to DST) is supported by the evidence about the lax attitude of Chelmsford overall to the obtaining of consent to ECT despite the hospital having a form for such consent (unlike the position with respect to DST where there was no form at all). The respondents pointed to numerous examples in their submissions in the following terms (which I accept):

- (1) Alan Field crossed out the words “electro therapy” on the consent form, yet was administered ECT by Mr Herron. In the next admission, staff noted that Mr Field did not appear to know he had previously received ECT and spoke of Mr Herron’s vitamin injections inducing frightening yellow lights. On 19 March 1977, Mr Field demanded that he have no more ECT, yet Mr Herron administered ECT to him on 21 March. On 22 March, staff noted that Mr Field thought he had had his last ECT, however Mr Herron administered another ECT the following day;
- (2) on occasions Mr Herron’s patients did not sign the consent form for ECT yet were nonetheless administered ECT. Many patients were not told they would be given ECT, and if they had known, would never have allowed it;
- (3) of the 25 Chelmsford records that were available for Mr Herron’s patients:
  - (a) three did not sign the authorisation for ECT, but were nonetheless administered it [Mr Hart: MED00095.2 (RTB7), Mr Hereford-Smith: MED00068.6 (RTB6), Ms Finch: MED00100.1 (RTB7)];
  - (b) one patient was treated with DST on five occasions, on one of which she received ECT having not signed the authorisation [Ms Websdale: MED00189.1 (RTB9)];
  - (c) one signed the authorisation form but crossed out all of the sections relating to ECT [Ms Ryan: MED00102.1 (RTB7)]; and
  - (d) five patients’ authorisation forms were signed by family or friends [Ms Murdaca: MED00012.1 (RTB7); Ms Wales: MED00055.1 (RTB6); Mr Williams: MED00079.1 (RTB6); Ms Spetere: MED000124.1(RTB8) and MED000125.1 (RTB8)];

- (4) on many occasions, Mr Herron administered ECT to patients of Dr Bailey where they had not signed the consent form. Many patients were not told they would be given ECT, and if they had known, would never have allowed it. Some patients of Dr Bailey thought the consent form was merely an admission form;
- (5) consent forms were signed by doctors and nurses rather than the patient. It was inappropriate for a doctor or nurse to sign a patient's consent to receive ECT: Parker XXN at T2226.14-15. Mr Dilworth, a nurse at Chelmsford, told patients that doctors would give ECT to the patients regardless of their refusal;
- (6) Mrs Ford refused to sign the ECT form, yet there is a scrawled undated signature on the form, that raised a serious question of authenticity with Ms Bothman, and therefore as to Mrs Ford's consent to the ECT administered by Mr Herron. ECT signatures have also been disputed by other patients of Mr Herron. Similarly, Mrs Cotis was adamant about not having ECT and Nurse Stewart noted that she had not signed the ECT form, yet on the front page appears an illegible signature apparently dated two days after admission and Mr Herron administered ECT to her. These examples are consistent with the suggestion by Mr Herron that in some circumstances, he lightened patients from sedation so they could sign the form: Herron 2 [78] (CB2, AFF000F, p 17). Clearly, that cannot have been informed consent; and
- (7) a number of patients who signed the ECT consent form were not in a state to give proper consent, both to ECT and DST. Nursing staff recall patients who were unable to understand the treatment due to being drunk.

476 As noted, there was no form for consent to DST from which I would infer an even more cavalier attitude at Chelmsford to the obtaining of consent to DST as compared to ECT. As the respondents pointed out:

Mr Herron treated patients without their consent to DST. For example, Mrs Walker was transferred to Chelmsford from Hornsby hospital by ambulance, during which she protested against being taken to Chelmsford [Walker pg. 10-11 (CB12 HN0149)], yet Mr Herron treated her with DST and ECT [MED00172 (RTB9)]. Another example is Rasma Meihubers, who was also a patient of Mr Herron. Mrs Meihubers said she had been admitted for a rest and that she should not be at Chelmsford: MED00206.12 (RTB10). The medical notes record that 'she does not know about the sedation + full of questions. Pt objecting to all the medication'. Despite this, Mr Herron ordered her sedation and treated with DST and ECT: MED00206.12 (RTB10). Another example is Alan Wilson. The nursing staff noted that he did not want sedation yet was nevertheless treated with DST: MED00001.20 (RTB4).

...

In addition to these, many patients of Mr Herron (where Mr Herron was involved in their treatment) were treated with DST where it was not explained to them. This practice is described by the nurses. Therefore, many of the patients did not consent to DST. It also cannot be said that the nurses at Chelmsford informed the patients adequately to satisfy the requirements of informed consent.

(Footnotes omitted).

477 Being told by a nurse that you would be put to sleep and would feel a lot better when you woke up (the effect of the evidence from nurses about “informing” the patient as to the proposed treatment) was hardly the provision of sufficient information about DST to constitute informed consent by the patient. Similarly being told by a nurse that ECT involved shock treatment which was very effective could not possibly have amounted to the giving of sufficient information to enable informed consent to being given to ECT while under DST, routinely given without the use of a muscle relaxant, oxygen or an anaesthetic which were standard requirements at the time.

478 The respondents noted that Mr Herron maintained that he relied on Dr Bailey to obtain consent from Dr Bailey’s patients under DST to ECT (which Mr Herron performed). However, Mr Herron knew that there were occasions on which the consent form for ECT had not been signed by Dr Bailey’s patients: see Herron XXN at T2657. As the respondents submitted:

It was suggested in cross examination by Mr Herron that he had relied on his more ‘senior’ colleague in Dr Bailey in this respect: T2692.22-4. Mr Herron has set out at length his experience as a psychiatrist at the time he was practising at Chelmsford, including that at the time he was the head of psychiatry at North Ryde Psychiatric Hospital. Mr Herron was a senior psychiatrist. He must have known how important consent was in respect of the delivery of ECT. His failure to ensure that the patients he delivered ECT to had consented to the procedure was as much his responsibility as it was Dr Bailey’s.

479 I accept all of these submissions for the respondents. They show a serious systemic problem with the obtaining of informed consent to DST and ECT at Chelmsford. Mr Herron knew about the problem but obviously was so steeped in the cavalier attitude to patient care at Chelmsford that he saw no apparent harm. It is a problem of which Dr Gill, given his role at the hospital, must also have been aware yet took no steps to correct. It was part and parcel of a deep-seated culture of the abuse of vulnerable persons which characterised the operations at Chelmsford in respect of the administration of DST and ECT. I reject the applicants’ submissions that the evidence does not permit conclusions to be reached about consent procedures which were in place at the time. The weight of the expert evidence is clear – informed consent was always required for treatments such as DST and ECT. Chelmsford had no documentary system for recording consent to DST. Its documentary system (such as it was) for recording consent to



ECT was open to abuse and was routinely abused. This reinforces my conclusion that it is likely that no patient gave informed consent to DST because no patient would have knowingly consented to a procedure with such a serious risk of harm and death had they been informed (as they should have been) about available alternatives and that DST was an experimental and unproven procedure. The suggestion that these patients, who were all voluntary admissions, were somehow so impaired that they could not give informed consent is nothing but speculation, diminishing their status as human beings entitled to know about the proposed treatment before being subjected to it. The suggestion that they are all fantasists or liars is equally unrealistic.

480 An example of the unreliability of the applicants' approach to the evidence of former patients and their relatives may be given. The applicants submitted that a patient of Mr Herron's, Mr Kerekes, gave an interview to police in which he said that his treatment at Chelmsford cured his depression and he had no desire to make any complaint because Mr Herron got him on his feet and back to work: HN0081, Ann B p.25 – 26. The applicants said on his next visit to the police Mr Kerekes "did a complete about-face" and made startling claims of mistreatment. It is then said he gave confused and contradictory evidence to the Royal Commission. This is said to be explained by Mr Kerekes being an active member of the Chelmsford Victims Action Group, being unduly influenced by Scientologists, being a liar and motivated by making a claim for money against Mr Herron. In fact, in his first statement to police it is apparent that according to Mr Kerekes Mr Herron gave him no information about the treatment he would receive. In other words, Mr Kerekes could not have consented to the treatment. However, he wanted no further action taken against Mr Herron as a result of his treatment (that is, being told nothing about the treatment before being given it) because he considered the treatment had allowed him to get back to work which was his main consideration. He also noted he now suffered severe headaches and mental blankness but said he could not relate those conditions to his treatment at Chelmsford. In his next statement to police there are allegations of him being forcibly prevented from leaving Chelmsford but the basic allegation of not having consented to treatment remains. He also now considered his memory had been adversely affected by his treatment at Chelmsford. Further, he believed that there was nothing much in fact wrong with him once he managed to withdraw from alcohol which he did at Rozelle Hospital and felt he had been misled by Mr Herron and the nursing staff at Chelmsford. The changes in his testimony do not mean he is a liar. He always maintained that he had not consented to the treatment he was given. Further, a person's perspective on the acceptability of what has been

done to them may well evolve over time, particularly if the events involve trauma which a person may not wish to admit or re-live. A person may also get details wrong (particularly when there are multiple admissions) but the essence of the testimony – that he was given treatment to which he did not give consent – remains consistent. Acceptance of the trauma and harm this has caused also may well take time for the person to recognise and acknowledge to themselves.

481 The evidence summarised above is proof of a systemic failure at Chelmsford to ensure that patients gave informed consent to treatments (DST and ECT) involving risks of serious harm which, consistent with the standards at the time, required informed written consent to be obtained. This manifest systemic failure is emblematic of the complete professional and ethical collapse which Chelmsford represents.

#### 7.4 Dr Gill

482 While Dr Bailey and Mr Herron were primarily involved in administering DST at Chelmsford the evidence also satisfies me that Dr Gill bears responsibility for the negligence, unethical conduct and medical malpractice involved in the administration of DST at Chelmsford.

483 Dr Gill personally administered DST to six patients, one of whom died. Given my conclusions above, this fact alone is sufficient to mean that Dr Gill was negligent and engaged in unethical conduct and medical malpractice.

484 Dr Gill was also a part owner of the company which owned Chelmsford, Fairfield Heights Community Hospital Pty Ltd (**FHCH**). The licensee of Chelmsford, Mr Silbermann, was one of Dr Gill's business partners in FHCH. As the respondents submitted, the reality of the day-to-day operation of Chelmsford involved Dr Gill in oversight of its management and operation given that Dr Gill was medically qualified and Mr Silbermann was not. As the respondents put it, the evidence discloses the following matters:

- (a) The various nurses provided evidence about the fact that Dr Gill was frequently at the hospital and that they saw him as the owner of the hospital;
- (b) Nurses at the hospital spoke to Dr Gill in relation to complaints about what was taking place at the hospital or when any new equipment was required.
- (c) Dr Gill was the person to call if there was a medical emergency at the hospital.
- (d) Joseph Silbermann, considered that he had delegated all matters relating to the hospital to Dr Gill: Silbermann pg. 43-44, 153-154 (CB11 HN0135) [I note that Mr Silbermann said 'it just came about that he slid into the role of taking charge of the day to day running'; he certainly considered Dr Gill the manager

of Chelmsford; the other owners implicitly approved of this arrangement; he was causing Chelmsford to be run in an efficient manner through Dr Gill].

- (e) Dr Gill's other business partners considered Dr Gill to be 'looking after the hospital' and 'running the hospital, as far as treatment is concerned'.
- (f) Dr Gill interviewed and dismissed nurses and matrons for the hospital.
- (g) Dr Gill wrote to the Department of Health as the 'proprietor' or 'director' of the hospital and met with Department of Health inspectors.
- (h) Dr Gill received correspondence relating to litigation involving Chelmsford Private Hospital and wrote various letters on the letterhead of 'Pennant Hills Community Hospital' after Chelmsford Private Hospital changed its name, including keeping the hospital's insurer informed about litigation.
- (i) Dr Gill was the person who delivered the message to Dr Bailey (following a meeting with his business partners) that he would no longer be entitled to practise DST at Chelmsford: Gill 2 [54] (CB2 AFF000B p9).

485 Based on the evidence, I agree with the respondents' submission that Dr Gill de facto controlled Chelmsford on behalf of its owners. As the person with such de facto control, Dr Gill had ultimate oversight of the treatments offered at Chelmsford and responsibility for ensuring that the treatments offered could be provided in a safe and appropriate manner. For the reasons given above, DST could never be provided in a safe and appropriate manner at Chelmsford and Dr Gill, given his medical training, should have known this from the moment he understood the nature of DST.

486 The fact that Dr Bailey and Mr Herron were specialists and Dr Gill was a more junior (in years of experience) general practitioner does not absolve Dr Gill of responsibility for permitting a highly dangerous treatment for which there was no justification from being provided in the hospital over which he had de facto control. Dr Gill was obliged by his ethical and professional duties as a medical practitioner to ensure the other owners knew what was happening and to ensure it ceased. As the respondents noted, Ms Ray, the owner of St Annes (where Dr Bailey had previously practised DST) and a nurse stopped Dr Bailey from using DST at that hospital because she told him that "it was too dangerous for us". Ms Ray had also said (which I accept) that all of the risks of DST "we felt were unethical and straight out dangerous" and that "[h]e [Dr Bailey] pretended there were not any dangers, and so did Dr Herron. They both pretended there was not any danger". I consider this perception was accurate. She also said that when she became aware of what was being done she consulted other doctors none of whom had heard of deep sedation therapy but who told her of the dangers, particularly pneumonia.

487 The fact that in 1978 Dr Gill did tell Dr Bailey he could no longer perform DST at Chelmsford (as this was the decision of the owners at that time including Dr Gill) demonstrates Dr Gill's

capacity to have ensured that the owners were all on notice of the problems from the outset and to have ensured that they recognised that cessation of DST at Chelmsford was an ethical and professional necessity. Until 1978 he did neither. Based on the expert evidence Dr Gill, being a medical practitioner and a person with de facto control of Chelmsford, acted negligently, unethically and committed medical malpractice in permitting DST to be performed at the hospital between the time of his taking part ownership and de facto control (1972) and the time DST ceased at Chelmsford (1979).

488 I do not accept the applicants' submissions to the contrary. The fact that a nurse or nurses did not view Dr Gill as the "medical superintendent" of Chelmsford is immaterial. The issue is not one of Dr Gill interfering in the treatment of individual patients. Apart from the fact that Dr Gill personally subjected six patients to an outmoded and dangerous treatment for which there was no justification at the time, Dr Gill was in de facto control of the hospital and thus responsible for determining what treatments could be offered in the hospital. The applicants' suggestion that the head nurse or matron was in control of Chelmsford (as if that excluded Dr Gill's de facto control over the treatments the hospital offered) is a nonsense. The head nurse may have had control of day-to-day operations but the head nurse could not and did not decide what treatments would be permitted to be performed at Chelmsford. That was the responsibility of the owners as the operators of the hospital and it is clear that the owners were acting through Dr Gill, a medical practitioner, with routine contact with the hospital to discharge this responsibility. After all, on his own evidence, Dr Gill and Dr Morgan (another owner) attended the sedation ward after purchasing the hospital to "review" it and the rest of the hospital and to see how they could improve matters. In conducting this review Dr Gill necessarily must have reached the view that DST could continue to be provided at Chelmsford. Yet Dr Gill must have understood the nature of DST from the moment he became involved with Chelmsford through his shareholding in FHCH. This is evident from the fact that on FHCH becoming the owner Dr Gill, on his own evidence, was directly involved in decisions relating to the provision of equipment in the DST ward as part of his "review".

489 The fact that the relevant legislation at July 1972 was the *Private Hospitals Act 1908* (NSW) which required the appointment of a Chief Nurse but no other medically qualified person does not change the fact that the operator of a hospital must decide what treatments are provided. The Chief Nurse could not make that decision. Only the operator could make that decision (see the evidence of Professor Hickie above). Dr Gill was the de facto operator of the hospital. It was his responsibility to ensure that only appropriate treatments were provided at the hospital.

The fact that the Chief Nurse was responsible for the day-to-day running of the hospital does not mean that Dr Gill was absolved of responsibility for ensuring that only appropriate treatments were provided at the hospital. The simple fact is this. When FHCH became the owner of Chelmsford Dr Gill personally involved himself in reviewing the DST ward and deciding what equipment and arrangements were suitable for the DST ward. In so doing he necessarily decided that it was appropriate for DST to be administered at Chelmsford. This decision (whether implicit or explicit in his mind) was without justification. He should have known that DST was too dangerous a treatment to be provided at Chelmsford. The fact that a hospital may not owe a duty of care to a patient for a treatment performed by a doctor pursuant to a direct engagement with the doctor (*Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553 at 604F-605E (Samuels JA), 607E (Meagher JA)) is immaterial. Chelmsford was providing the day-to-day care of these patients, not the doctors. In that context it was under a non-delegable duty of care to its patients which must have extended to ensuring that they were not subjected to a dangerous treatment in the hospital for which the hospital could not safely provide. As a doctor representing the owners in his dealings with Chelmsford, Dr Gill was responsible for ensuring the hospital did not permit this dangerous treatment to continue – yet he both permitted it (until the hand of the owners was forced by the position of other doctors in 1979) and personally administered the treatment in the hospital to six patients.

## **7.5 Deaths at Chelmsford**

490 There is no issue on the evidence that both Mr Herron and Dr Gill knew patients had died whilst undergoing DST at Chelmsford and continued to provide DST to patients at Chelmsford thereafter. Contrary to the evidence of Professor Parker about minimum acceptable standards there was no cessation of the practice of DST, no immediate investigation, and no taking of corrective strategies by either applicant. There seems to have been no recognition by Mr Herron and Dr Gill that they were involved in something “calamitous and catastrophic”, as Professor Parker described it. Despite the deaths, Mr Herron continued to administer DST until early 1979. Dr Gill’s patient John Adams died under DST but Dr Gill gave another patient very similar DST a few weeks later.

491 A report prepared by Dr Bryan Gandevia, a respiratory physician, for the Royal Commission is in evidence. The report refers to 26 deaths at Chelmsford in patients undergoing DST (based on the evidence of death certificates). He found that the outstanding feature of the deaths was the preponderance of young people nearly half being under the age of 40 and two thirds under

the age of 50. The mean age at death was 41.7 years which is grossly abnormal by comparison with general mortality data. Further, Dr Gandevia described the most striking feature as that eight of the deaths arose from coronary occlusion or myocardial infarction. For nine deaths pneumonia was a feature which Dr Gandevia considered almost certainly to be an underestimate given the evidence of respiratory difficulties in the nursing notes. Dr Gandevia said this is the mode of death which might be anticipated in people who are heavily sedated and confined to bed. Staphylococcal pneumonia was implicated in three cases but was a very rare condition. There were three cases of pulmonary embolism or infarction, a mode of death which also might well be anticipated in sedated patients confined to bed. Cerebrovascular accidents occurred in six cases which is common in older age groups but it was remarkable to note three deaths at age 45 or less, one aged 20. Table 4 shows the distribution of deaths by year as follows:

1964	5
1965	1
1966	2
1967	2
1968	0
1969	1
1970	1
1971	1
1972	2
1973	2
1974	3
1975	2
1976	1
1977	2
1978	0
1979	0
1980	1

492 Dr Gandevia excluded two of the deaths as not having a sufficiently close relationship to DST at Chelmsford and said a third might fall into this category but all the other cases (23 in total) bore some immediate relationship to DST at Chelmsford.

493 According to Dr Gandevia the overall mortality amongst admissions at Chelmsford appeared  
to be 23 per thousand which is “remarkably high”. He compared causes of death at Chelmsford  
with national averages and said while the calculations were crude:

...the indications are clearly that the Chelmsford mortality is at least an order of  
magnitude above that which might be expected from these specified causes in the  
general population...

494 He concluded that:

Based almost entirely on an analysis of the death certificates or supposed causes of  
death, there is clear evidence of an abnormal mortality amongst Chelmsford Hospital  
patients. Cardinal factors in reaching this conclusion are the relative youth of the  
patients, the overall mortality and the mortality from certain specified causes of death.

495 He said the pattern could not be explained by the contributory cause of the patients having  
psychiatric conditions as in general terms such patients do not carry enhanced mortality  
excluding suicide. He noted:

The common pattern of death, where it is apparent to me from the data supplied, is of  
cardiac and/or respiratory arrest, the nursing notes suggesting strongly a dominant  
respiratory component. This respiratory component is what might be anticipated in  
patients who are heavily sedated.

496 He noted that:

In heavily sedated patients, I would anticipate, as a respiratory physician, two  
complications. The first would be pneumonia and the second pulmonary embolism  
from a peripheral thrombosis, commonly in the calf, femoral or perhaps pelvic veins.  
From the point of view of pneumonia one would anticipate a close watch on  
temperature and respiratory rate, as well as noisy breathing suggestive of sputum  
retention. In the event of symptoms suggestive of pneumonia, I would consider heavy  
sedation contraindicated.

497 It is apparent that Dr Gandevia must have worked on the basis of about 1000 patients receiving  
DST at Chelmsford, with 23 deaths immediately associated with the treatment, or 2.3%. As  
noted above, Professor Whyte calculated a death rate at Chelmsford associated with DST of 17  
per 1000 or 1.7%. The applicants contended that their Table D showed that DST was a safe  
treatment with a lower death rate than psychosurgery. The assertion is unsupportable. As noted,  
it cannot be said that the therapies the subject of the table are DST. The precautions taken are  
not known or not able to be meaningfully compared to DST. Dr Smith considered that the  
mortality rate for prolonged narcosis therapies was between 1% and 5% which made it some  
10 times more dangerous than leucotomy procedures (0.3%) and 100 times more dangerous  
than a course of ECT (0.03%). The applicants relied on Mr Herron’s estimate that at least 3000  
patients had DST at Chelmsford while Dr Bailey mentioned higher numbers of patients. I

would not accept either estimate. Mr Herron and Dr Bailey both had reason to inflate the number of treatments in order to minimise the apparent death rate. Dr Gandevia's report proves 23 deaths immediately connected to the patient undergoing DST at Chelmsford. On the applicants' submission (based on Mr Herron's evidence of 3000 treatments) the death rate would be 0.76% but, as noted, I would not accept Mr Herron's estimate, let alone Dr Bailey's higher estimate of the number of patients treated with DST at Chelmsford.

498 I do not accept the applicants' submissions that Dr Gandevia's report should be approached with great caution. It may be accepted that his report was prepared for the Royal Commission and that the underlying material with which he was briefed (apart from the death certificates and at least some of the nursing notes) is unclear. His expertise as a respiratory physician, however, is not in question. There is no valid reason to discount his opinions merely because he was not available for cross-examination. The fact that Dr Gandevia excluded three of the 26 deaths as unrelated to DST at Chelmsford tends to support rather than undermine the credibility of his evidence. It also lends weight to his opinion that 23 of the deaths were directly related to DST at Chelmsford. The idea that Dr Gandevia, having excluded three patients, would not have satisfied himself that the other 23 deaths which he identified as immediately related to DST at Chelmsford were in fact so related is far-fetched. It may be accepted that the medical records of a number of those patients are not in evidence, but the applicants' submission that there is no proof that they received DST at all overlooks the probative value of Dr Gandevia's report – a report prepared for a serious purpose where it could be expected that Dr Gandevia would exercise significant care and scrutiny. Further, the limitation on his own work which he expressed also tend to support the high level of care with which Dr Gandevia prepared his report, leading to the view that his overall conclusions about the rate of deaths immediately relatable to DST at Chelmsford are reliable. Dr Gandevia's report is probative evidence of its contents, including a death rate from DST at Chelmsford of in the order of 2.3%.

499 Further, in his evidence in the Royal Commission Mr Herron admitted the fact of 26 deaths caused by DST, giving evidence as follows:

Q. You know now with the benefit of hindsight that there are at least 26 people who died during or immediately after sleep therapy.

A. Yes.

Q. And you know, do you not, in the overwhelming majority of those cases the deep sleep was probably causative, but at least a significant contributing factor to the deaths.

A. Yes.



500 These admissions against interest are entitled to significant weight. It may readily be inferred that Mr Herron would not have made such admissions unless the evidence to support them was overwhelming and, in effect, the admissions were unavoidable. While he has now changed his mind about DST being the cause of death, saying in this proceeding that DST was not significant in the deaths, this was the unqualified opinion which Mr Herron gave at a time closer to the events in question and when, it may be inferred, he was suffering no cognitive deficit due to old age. As the respondents submitted this:

...was an admission made by an experienced medical practitioner who was intimately connected with the treatment, had an opportunity to observe its effect, and who had had a period to reflect on it. It should be accepted as correct without hesitation for those reasons. It is in for all purposes.

501 The respondents also relied on evidence Mr Herron gave in this proceeding to the effect that he increased doses of barbiturates over time to see if they had the reported toxicity. The respondents described Mr Herron as undertaking experiments with increasing doses to see what dose could be reached without killing the patient. I have accepted above that DST itself was an experimental treatment. However, I do not consider the evidence Mr Herron gave should be taken to mean he was intentionally increasing the doses of barbiturates to see how high a dose he could reach without killing the patient. This evidence was given while Mr Herron was in hospital after he had suffered a number of falls and a head injury with material impact to his cognition. The evidence is not consistent with the pro-forma treatment sheets which involve the same dose range for the barbiturates irrespective of any individual characteristics of the patient (what Professor Parker accurately described as a template being applied to patients in a procrustean manner).

502 I do not accept the applicants' submissions to the effect that the respondents have not proved that DST caused deaths at Chelmsford. Based on the evidence of the serious risks presented by DST, the kinds of complications to which DST is expected to give rise, the evidence of Professor Whyte about dosage regimes and the death rate he calculated from DST, the report of Dr Gandevia, and the admissions of Mr Herron, I consider that it can be safely inferred that DST caused (in the sense that it was a material contributor to) no less than 23 deaths at Chelmsford. The evidence I accept suggests a death rate between 1.7% and 2.3%; that is, on any view, DST involved a real risk of killing the patient. The applicants' approach to the issues of proof is unrealistic. The weight of the evidence overall is compelling. It is not difficult to conclude that DST caused 23 deaths in circumstances where there is evidence that 23 deaths were immediately related to the administration of DST and DST involved such a significant

risk of death. Even without Mr Herron's admissions to the Royal Commission, the evidence is sufficient to be satisfied that DST caused the death of 23 patients. The evidence discussed below also further confirms that DST caused the deaths of patients. In considering the deaths of these patients it must be recalled that:

- (1) at the time there were no indications for the drug regime used in DST at Chelmsford;
- (2) a simple risk-benefit assessment would indicate DST involved a very high risk of serious, potentially life-threatening, adverse effects with minimal or no benefits;
- (3) the use of prolonged narcosis was effectively abandoned throughout the world by the late 1950s because it was found to be an ineffective and highly dangerous treatment and because the introduction of major and minor tranquilisers and antidepressant drugs allowed for the more appropriate treatment of patients with little risk of death or serious side effects (the validity of this conclusion is not contradicted by the fact that the applicants were able to identify a very few doctors in the world who were still experimenting with narcosis therapies in the 1960s and 1970s);
- (4) DST has never been established empirically as a valid treatment for specific psychiatric conditions or as a non-specific modality having benefit across a range of psychiatric conditions;
- (5) DST involved complex polypharmacy which would have been difficult to manage even by a skilled anaesthetist, let alone nurses basing their responses on mere observations;
- (6) the practice of DST was not based on any acceptable scientific rationale which existed at the time and had no justification. It was an idiosyncratic and experimental treatment placing the patients at such a high risk of harm that they could only be looked after in an intensive care unit or intensive care bed (before such units were available). Each patient who was treated with DST at Chelmsford was managed in a non-acceptable/callous/reckless manner, with treatment placing each patient at risk for immediate complications, and adverse long-term consequences;
- (7) the availability of alternative treatments with much lower risks of harm and much greater evidence of benefit by the mid to late 1960s meant that a professional and ethically-based approach required the cessation of all coma-based therapies. From the mid-1960s onwards any further development of coma based therapies could only be considered as experimental and well beyond the scope of normal practice; and

- (8) a reasonable medical doctor should have readily understood what the physical risks of such a treatment might be. It was obvious DST was much more harmful than beneficial and it conflicted with the first principle of medical practice to do no harm.

### **7.5.1 Audrey Francis**

503 Ms Francis, aged 66, died while undergoing DST at Chelmsford.

504 Ms Francis had a long history of alcohol abuse and depression. She had been admitted to psychiatric facilities associated with these conditions on numerous occasions. She was admitted to Ryde Hospital in March 1976 where tests showed that she:

- (1) had a heart size in the upper limit of normal, but no evidence of left ventricular failure: Herron XXN at T378.37-40;
- (2) had non-specific ST, T wave changes to electrical activity of the heart (at MED00093.6 (RTB7)), which is an indicator of heart issues: Herron XXN at T378.42-43; and
- (3) may have had liver damage: Herron XXN at T379.12-13.

505 Mr Herron was called in as a consultant to assess Ms Francis at Ryde Hospital. In consulting I infer that Mr Herron would have become aware of the test results referred to above. Mr Herron decided that Ms Francis should be treated with DST at Chelmsford. I do not accept Mr Herron's evidence that Ms Francis demanded to be treated with DST and knew a great deal about it. This seems far-fetched. Had she been so keen on the treatment she could have sought it an earlier time given her numerous previous admissions. The fact that the treatment was only raised in consultation with Mr Herron, who was administering DST to other patients at Chelmsford, indicates that Mr Herron recommended the treatment. As Dr Phillips said Mr Herron was ethically bound to:

- (a) explain the methodology underpinning DST including the drugs used to induce and maintain deep sedation;
- (b) explain the likely gains to be achieved by DST (if any);
- (c) explain the potential risks associated with DST;
- (d) explain alternate methods of treatment; and
- (e) record all matters relating to consent for DST and obtain signature.

506 Given the risks of death and serious complications associated with DST and the availability of safer and better alternative treatments I am unable to accept any suggestion that Mr Herron

complied with these obligations. Rather, he decided to subject Ms Francis to an experimental treatment involving serious risks of harm for which there was no indication and despite safer and proven to be efficacious alternatives being available. This was gross negligence, unethical and medical malpractice.

507 As the respondents submitted:

Ms Francis was admitted to Chelmsford on 12 March 1976 at 8am under the care of Mr Herron: MED00089.1 (RTB7), MED00090.2 (RTB7). He was not present when she was admitted but nonetheless directed that she begin DST immediately: Herron XXN at T379.39-47, T380.9, T394.8-9. DST commenced at 2pm that day: MED00090.2 (RTB7); Goedde pg. 147 (CB6 HN0049).

At the time DST commenced, it had been a week since Mr Herron had conducted any in person physical or psychological examination of Ms Francis. He did not contact Dr Nash and therefore was not aware that she had been assessed by him: Herron XXN at T380.15-16. He did not arrange for someone else to conduct a physical examination: Herron XXN at T384.12-17. There is no evidence that he took any steps to discover the quantity of gin, Surmontil or Hemineurin that Ms Francis had consumed: Herron XXN at T380.11-13.

Dr Phillips' unchallenged expert opinion is that, given Ms Francis' age and history of heavy drinking and falls, a careful physical examination would have been mandatory prior to the commencement of DST with a particular emphasis on the neurological system: EXP0009.5-6 (RTB1); EXP00012.14 (RTB1).

Although some tests were carried out at Ryde District Hospital, given there was a period between her discharge from that hospital and admission to Chelmsford during which time she could have suffered further falls or developed infection, it would have been wise to repeat a chest x-ray and basic biochemistry prior to the administration of any psychoactive medication or an anaesthetic: EXP0009.6 (RTB1).

While pathology swabs were taken by a nurse on admission, Ms Francis' treatment with DST commenced before the results of those tests were known: MED00089.7 (RTB 4). The results indicated she had a slightly higher than normal white cell count: MED00089.2 (RTB4); Phillips XXN at T1769.10-26.

A white blood cell count marginally above the reference range would immediately alert the physician or psychiatrist to the possibility of infection: Phillips XXN at T1769.33-34. Therefore, while the elevation was not large, it was sufficient to put the treating doctor on notice that further investigations were required.

Mr Herron accepted during cross-examination that if Ms Francis had an elevated white cell count it showed that she had a mild infection: Herron XXN at T388.11-16.

Even if the elevated white cell count was linked to Ms Francis' suspected subdural haematoma, her physical condition was clearly relevant to the management of her treatment. Dr Phillips' view is that if there was a cogent reason for DST to be performed on any patient then the highest level of safeguards would need to have applied: Phillips Report [45(1)] (CB3 REP0012).

Given Ms Francis' history, it was inappropriate for Mr Herron to order that DST commence without conducting a further physical examination or obtaining the results of the pathology tests.

508 It is apparent that Ms Francis was treated in accordance with the pro-forma treatment sheet. As the respondents submitted, the sheet was signed by Mr Herron and dated 12 March 1976: MED00089.13 (RTB7), although there is no evidence that Mr Herron was present at Chelmsford on 12 March 1976. As the respondents put it:

Mr Herron said ‘I don’t backdate treatment forms’ at T397.16-17. However, he accepted that he was not present when Ms Francis was admitted on 12 March and instead gave instructions about her treatment over the phone: Herron XXN at T394.8-9; Herron 2 [105] (CB2 AFF000F, pg. 21).

509 The respondents’ submissions, which are supported by the evidence continued:

DST commenced at 2pm on 12 March 1976 when Ms Francis was administered 500mg of Sodium Amytal and 6mg of Serenace: MED00089.11-12, 14 (RTB7); Goedde pg. 147 (CB6 HN0049). She was then moved to the DST Ward (MED00089.14) and administered 400mg of Tuinal at 6pm at 10pm: MED00089.10 (RTB7).

Between 2pm on 12 March and 1.30am on 14 March 1976, Ms Francis was administered 3,600mg of barbiturates (MED00089.10, RTB6), which is a substantial dose: EXP00009.3 (RTB1). During this period, her:

- (a) blood pressure dropped to 95/60 on 12 March requiring her bed to be placed on blocks: MED00089.14 (RTB7); and
- (b) temperature rose to 37.5 degrees on 13 March.

The expert evidence is that a temperature of 36.6 degrees is normal (Phillips XXN at T1679.25-26) whereas a temperature of 37.5 degrees is abnormal and would be unlikely to be neglected (Parker XXN at T2231.19-24).

The amount of barbiturates administered to Ms Francis would have caused some depression of her vital centres controlling respiration and heart rate and predisposed her to the development of pneumonia: EXP00009.5 (RTB1).

On 13 March 1976, Mr Herron gave Ms Francis ECT with anaesthetic (MED00089.14) but not muscle relaxant: Herron XXN at T393.38-394.1. She was not given oxygen: Herron XXN at T394.3. It was unusual practice at the time not to administer a muscle relaxant and not to give oxygen pre- or post-ECT: EXP00012.12-13 (RTB1).

It was also unusual practice at the time for Mr Herron not to make an entry into Ms Francis’ file when he treated her: EXP00012.12 [D(2)] (RTB1).

This was the only occasion that Mr Herron attended on Ms Francis during her Chelmsford admission prior to her death: Herron XXN at T394.5-6.

On 14 March 1976 at about 1.30am, Sister King administered to Ms Francis 400mg of Tuinal: MED00089.10. Following this sedation, Ms Francis began snoring loudly: King pg. 6 (CB9 HN00083). When Ms Francis stopped snoring Sister King checked on her and could feel no pulse and she was not breathing: King pg. 6 (CB9 HN00083). Sister King administered oxygen to Ms Francis and asked another nurse to notify Ms Fawdry: MED00089.15; King pg. 6 (CB9 HN00083). Sister King and Ms Fawdry attempted to resuscitate Ms Francis using an external heart massage without success: King pg. 6 (CB9 HN00083).

510 I also accept the respondents’ submissions to this effect:

- (1) at the time it was administered to Ms Francis DST was not indicated for any condition from which she suffered (or, indeed, any condition apart from the traumatic brain injury posited by Professor Whyte);
- (2) there was a high risk of adverse events associated with the drugs administered to patients during DST, which was of such a level that the benefit to the patient would have to be enormous to make those risks worthwhile and there is no cogent evidence of any such benefit (and, indeed, the evidence is to the contrary);
- (3) while the toxic dose of barbiturates varies from person to person, it is often not greatly above the dose required to induce sedation. In this regard, contrary to the applicants' submissions, there is no sound evidence from which it would be inferred that Ms Francis had a particular tolerance for barbiturates;
- (4) Mr Herron admitted during cross-examination that Ms Francis had an elevated risk of mortality because of her weight and physical condition: Herron XXN at T377.10-14. He was therefore clearly conscious that subjecting her to a treatment such as DST, which puts strain on the body including reducing respiratory function, would increase that risk;
- (5) Ms Francis was given 3,600mg of barbiturates in a period of about 36 hours: MED00089.10 (RTB6). A comparison to the figures in Professor Whyte's report shows that this was a very significant dose, more than double the dose associated with severe toxicity;
- (6) at the time of her death, Ms Francis level of blood barbiturate was 11.3mg per litre, consisting of 8.2mg of amylobarbitone and 3.1mg of quinalbarbitone per litre of blood: MED00088.2 (RTB6); and
- (7) in the Royal Commission and in this proceeding Mr Herron accepted that a blood barbiturate level of 11.3mg was at the lower end but within the potentially lethal range: Ex. 48, Tab 7, p T698; Herron XXN at T2456. 28-42.

511 Given these matters I am satisfied that DST caused the death of Ms Francis.

512 I reject the applicants' submission that "the respondents have failed to prove that any aspect of Dr Herron's treatment of Ms Francis was unreasonable, let alone grossly negligent."

513 For the reasons already given it was grossly negligent, unethical and medical malpractice for Mr Herron to subject Ms Francis to DST. She died from the treatment which given its serious

risks and her physical condition was not outside the reasonably expected range of outcomes for her.

### 7.5.2 John Adams

514 Mr Adams, a 25 year old, had to be resuscitated while under DST at Chelmsford and died a week later in Hornsby Hospital after his transfer from Chelmsford.

515 As the respondents submitted:

- (1) Dr Gill's use of sedation therapy was based on discussions with Dr Bailey: affidavit of Dr John Gill dated 31 January 2020 (**Gill 2**) [90(a)], (CB2 AFF000B, p 15);
- (2) Dr Gill carried out no independent research but simply talked to the other doctors administering DST and observed the way it was administered at Chelmsford;
- (3) Dr Gill initially used Dr Bailey's pro-forma treatment sheet for Mr Adams' first treatment with DST;
- (4) in subsequent admissions of Mr Adams, Dr Gill used Lethidrone, an opiate antagonist, in conjunction with Tuinal (and sodium amytal) to allow drug addicts to withdraw quickly, while sedated. There is no evidence that Dr Bailey or Mr Herron used this combination of drugs. Dr Gill appears to have come up with the combination on his own without any research or consideration of the potential for drug interactions; and
- (5) as noted, DST warrants the description of an experimental treatment for which there was no supporting evidence of benefit, and Dr Gill's treatment modification of the polypharmacy used in DST was itself experimental.

516 I also accept the respondents' submissions to this effect:

Dr Gill accepted that Mr Adams died because of a period of 'respiratory sleep apnoea' and that this condition is made more likely when a person is treated with sedatives, including barbiturates: Gill XXN at T288.21-289.2. For that reason, Dr Gill said he 'did not disagree' with the proposition that the drugs he prescribed to Mr Adams contributed to Mr Adams' death: Gill XXN at T289.6-17. At the Royal Commission, Dr Gill described the drug treatment as a 'significant contributory cause to the sleep apnoea', but for an unexplained reason could not accept that in these proceedings, saying that it 'is a question of degree': Gill XXN at T289.28-36.

For those reasons, Dr Gill's own evidence is that the DST he gave to Mr Adams at Chelmsford contributed to his death.

517 The applicants sought to escape the effect of Dr Gill's own evidence, saying:

Dr Gill told this Court that he does not now disagree with the proposition that the drugs he prescribed would have been a contributing factor to Mr Adam's death: T289.15. Dr

Gill now has limited present memory of these events: see AFF000B [59]. Dr Gill had told the RC [Royal Commission] that with the benefit of hindsight he felt that John Adams probably had a period of respiratory apnoea to which the drugs he administered would have been a significant contributory cause: T287.1-36; Ex 12(3) p288. The RC occurred about 12 years after the events in question. Dr Gill had expressed the view in 1980 that there was nothing about Mr Adam's condition that was inconsistent with the previous treatments and there was no special risk of respiratory arrest: Ex 12(8), OTH00044.123. Dr Gill was not an expert physician (then or now) and is not qualified to in fact express a view as to Mr Adams' cause of death - anything he says on the topic (or said to the RC) could not properly be considered an admission as it is speculative.

518 I disagree. Dr Gill was medically qualified. The expert evidence is to the effect that any reasonable medical practitioner would have appreciated the serious risks involved in the administration of DST. The risk that eventuated in the case of Mr Adams is precisely the kind of risk that was inherent in DST. The applicants' assertions about Mr Adams' levels of tolerance to barbiturates involve nothing more than speculation. The fact that Mr Adams was a drug addict who might have died from his addiction does not mean that it was reasonable to subject him to a treatment involving a significant risk of death. Death from a self-administered overdose is one thing; death from a medical treatment intended to benefit the patient is another altogether. Dr Gill was in no position to make the judgment he said he did that he considered the mortality rate of 1% to 3% for DST was acceptable given high rates of morbidity in drug addicts. If this is the calculation Dr Gill made at the time then it breached the fundamental first principle of medicine of doing no harm. Nor was there any rational basis for Dr Gill's view that his reaction to the mortality rate of 1% to 3% was "this was a standard treatment used by a respectable minority of doctors". There is no evidence as to how Dr Gill came to this view. By the time he was using DST it was not a standard treatment and nor was it used by a respectable minority of doctors. It was an outmoded experimental treatment involving serious risks and having no justification for any indication including drug addiction.

519 The standard of care Mr Adams received at Chelmsford is also questionable. He was observed to be grey in colour at 8.00am but breathing normally so nothing was done. By 8.25am he was not breathing and had no pulse. Sister Rogers inserted a guedels airway and Matron Fawdry sucked out his nose and airway. The other sisters assisted and someone administered oxygen with the air-viva mask. Sister Rogers commenced cardiac massage. However, it is apparent that it was only the intervention of a doctor who fortuitously happened to be in attendance at the hospital at the time which enabled the resuscitation of Mr Adams. As the applicants noted, Dr Wyndon an anaesthetist who was at the hospital that morning attended and administered Methedrine to Mr Adams and his pulse returned: Exhibit (Ex.) 12 tab (6) p 43. An ambulance



had been called and Mr Adams had commenced intermittent breathing before he left at about 9.00am. As the respondents put it:

The complete inadequacy of the equipment in an emergency situation can be seen by reference to what happened with John Adams. Mr Adams had stopped breathing: Ex. 12, Tab 6, pg. 43. He was only able to be resuscitated and taken to Hornsby by reason of the ‘fortuitous chance’ that Dr Windon was arriving at work at the time: Fawdry XIC [examination in chief] at T1514.12. Dr Windon resuscitated Mr Adams by way of what Ms Fawdry referred to as ‘Magills intubation’: Fawdry XIC at T1513.19-25.

520 While he died a week later in Hornsby Hospital, the inference that DST was a material contributor to (and thus a cause of) Mr Adams’ death cannot be avoided. As the respondents noted, Mr Adams’ death was considered by Professor Whyte. The mean defined daily dose of barbiturates with which Mr Adams was treated was 14.00. That is equivalent to 1,400 mg/day, which is about 40% more than the dose associated with severe toxicity.

521 The respondents’ submissions to the following effect must also be accepted:

- (a) Dr Gill’s evidence was that he did not accept that his patients were given deep sleep therapy and that he gave his patient John Adams ‘light’ sedation. That is contrary to what Dr Gill told the Royal Commission where he clearly stated his involvement in ‘Deep Sleep Therapy’ and set out his reasons: Ex. 12, tab 2, pg. 4. It is also contrary to the actual regime of drugs given to John Adams, which involved the maximum number of drugs with the minimum amount of time between doses: Gill XXN at T269.6-10.
- (b) Dr Gill’s evidence about ‘light’ sedation was also flatly contradicted by nurses’ notes. For example, in respect of patient MA, Dr Gill insisted that she was given ‘light’ sedation: Gill XXN at T283.9-10. But the nurses notes record that ‘Deep Sedation commenced at 10:10am’: Ex. 12, tab 4, pg. 68. The Court should accept that if Dr Gill had instructed the nurses to carry out anything other than ‘deep’ sedation, it would have been recorded here. Dr Gill’s attempted reconciliation of the note with his own evidence was nonsensical.
- (c) Dr Gill denied that his initial treatment of John Adams used the same regime of drugs as Dr Bailey: Gill XXN at T215.14-16. It clearly did: the same pre-printed standard treatment sheet was used. He used the same treatment sheet for patient MA. What’s more, Dr Gill’s own evidence was that his use of sedation therapy was based on discussions with Dr Bailey: Gill 2 [90(a)] (CB2 AFF000B, pg. 15).
- (d) Dr Gill could not explain the stark contrast between his evidence to the inquest of John Adams that he was ‘absolutely satisfied’ with the level of nursing care and his evidence to the Royal Commission that the monitoring of patients in the DST ward was not good enough on that occasion.

522 For the reasons already given it was grossly negligent, unethical and medical malpractice for Dr Gill to subject Mr Adams to DST. As the respondents also observed, Dr Gill gave evidence that he stopped treating drug addicts with DST after Mr Adams’ death but in fact Barry Green

was another such patient who was admitted to Chelmsford for DST under Dr Gill less than one month after John Adams' death: Ex. 12, Tab 5.

### **7.5.3 Peter Clarke**

523 Mr Clarke, aged 31, died while being administered DST at Chelmsford under Dr Bailey.

524 He died on the sixth day of his DST administration. As the respondents record, Mr Clarke had various complications while under DST. At various points he was very mucousy and had an elevated temperature, with the nurses' notes indicating "Pt does not look well": MED000148.18 (RTB8). However, his wife was told he was doing well up to the point four hours before he died. Mr Herron also administered ECT to Mr Clarke about 30 minutes before he died.

525 Dr Hassall expressed the opinion to the Royal Commission that:

It is difficult to avoid the conclusion that treatment at Chelmsford Private Hospital did indeed contribute to this patient's illness and death.

Even if the cause of death was correctly stated, and if Mr Clarke did indeed die ... of a coronary occlusion, it would be difficult to dissociate that event from the effects of sedation and E.C.T., and their possible contribution to hypoxia and its effect on the myocardium (heart muscle) of the deceased.

526 Dr Hassall also expressed the view that "the central depressant effects of barbiturates, administered in quantities sufficient for deep sleep therapy, would be equivalent to general anaesthesia for the purpose of the Coroners Act".

527 The applicants' criticisms of Dr Hassall's opinions because he was unavailable for cross examination are without merit. There is no evidence that Dr Hassall was doing other than giving his impartial opinion to the Royal Commission as to DST being a material contributor to Mr Clarke's death. The fact Mr Clarke died under DST of precisely the kind of complications that can be expected with DST supports Dr Hassall's opinion. It is mere speculation by the applicants to posit that Dr Hassall was fallaciously equating a correlation with causation. Nor is their evidence that he was affected by confirmation bias.

528 The applicants contended that:

Mr Clarke's significant acute psychiatric condition, his size, history of untreated high blood pressure, and fluctuating weight put him in a significantly greater than usual danger of dying with or without treatment: Clark REP000A [7.37]-[7.55].

529 However, the fact is he died under DST. There is a world of difference between dying from  
some natural cause and dying while being subjected to a dangerous purported treatment for  
which there was no medical justification. Based on the evidence I do not accept the applicants'  
submission that:

The evidence available to this Court is insufficient to establish that treatment or care  
administered at CPH caused Mr Clarke's death. There is no evidence that either  
applicant caused or could have prevented Mr Clarke's death.

530 Dr Gill could and should have ensured that DST was not administered at Chelmsford. Mr  
Herron could and should have refused to perform DST on patients and could and should have  
refused to perform ECT on patients who were under DST as this was itself an experimental  
treatment.

#### **7.5.4 Miriam Podio**

531 Ms Podio, aged 26, died after being administered DST at Chelmsford.

532 Ms Podio was admitted under Dr Bailey. As the respondents pointed out:

- (1) Ms Fawdry recorded Ms Podio's history before moving her to the sedation ward and  
administering an intramuscular injection of 500mg of sodium amytal and 10mg of  
Serenace: MED00058.20-21 (RTB6); MED00058.6 (RTB6). This was despite the fact  
that sodium amytal was not prescribed on Ms Podio's treatment sheet: MED00058.15  
(RTB6);
- (2) Ms Podio was administered DST from about 28 July to 8 August 1977: MED00058.21-  
34 (RTB6) and ECT daily from 29 July to 11 August (excluding 5 August) 1977;
- (3) she became unwell during DST within hours of the treatment commencing, with her  
blood pressure dropping to 84/50 (MED00058.21-22 (RTB6)), a dangerous level, and  
remaining low for 48 hours (EXP00043.1 (RTB2)). Her other symptoms included:
  - (a) producing large amounts of thick, yellow mucous on 4 and 5 August  
1977: MED00058.28-29 (RTB6);
  - (b) aspirating coffee ground stained fluid on 29, 30 and 31 July  
(MED00058.23-24) and 6 and 7 August (MED00058.30 RTB6, 32;  
Jackson pg. 79-80 (CB8 HN0075));
  - (c) experiencing frequent hiccups on 30 July 1977 (MED00058.23  
RTB6), which was unusual: Jackson pg. 61 (CB8 HN0075);
  - (d) offensive breath on 31 July, 1 August and 2 August 1977;
  - (e) having an elevated pulse during her treatment, including of 120 on 31  
July and over 140 on 6 August 1977: MED00058.8-9 (RTB6);

- (f) elevated temperatures on 3 and 4 August 1977: MED00058.27 (RTB6);
  - (g) vomiting on 5 and 6 August 1977: MED00058.29-30 (RTB6); and
  - (h) having further erratic blood pressure readings on 7 August 1977: MED00058.32 (RTB6);
- (4) Ms Podio's rising temperature and pulse and her moist chest suggest she may have developed pneumonia during DST: Smith XXN T1937.20-T1938.16;
- (5) Dr Bailey prescribed antibiotics by phone prior to DST commencing and she continued to be given Velosef until 6 August 1977 (MED00058.6 (RTB6)), which given her condition at that stage, was clearly ineffective in dealing with her symptoms;
- (6) during the night shift on 5 August 1977, Ms Nicholson observed that Ms Podio passed a small amount of melaena stool (indicative of bleeding): MED00058.30 (RTB6). The applicants dispute this but as the respondents said the applicants could not have known at the time that Ms Nicholson was incorrect in her observation. No inquiries about the observation were made and there was no follow up of this observation; and
- (7) from 6 to 8 August 1977, Ms Podio's abdomen was very distended and she required catheterisation as she was not passing urine (MED00058.31-33 (RTB6)), she had no bowel sounds and a flatus tube was passed without result: MED00059.34. On 7 August 1977, she was commenced on Erythromycin, an antibiotic, as she was obviously not well. However, she continued to be administered the maximum dose of Tuinal during this time, except on one occasion: MED00058.3-4 (RTB6); Fawdry XXN T1446.39-1447.19. It was not until 8 August 1977 that she was given a high salt and water enema, lightened out of DST (MED00058.34 (RTB6)), and transferred to a general ward for observation: MED00059.15 (RTB6).

533 The respondents submitted, and I accept that:

It was Dr Phillips' view that Ms Podio should have been transferred to a general hospital at least by the afternoon of 6 August 1977: EXP00012.6 (RTB1). This is supported by the nurses' evidence that Ms Podio's condition was clearly cause for concern and that she should have been treated at a general hospital: Fawdry RXN at T2194.19; Jackson pg. 61-62 (CB8 HN0075); Switzer pg. 37 (CB11 HN0143). Dr Bailey and both Applicants were all involved in Ms Podio's care, and should have organised for her to be transferred to a general hospital.

534 Ms Podio continued to be unwell while in the general ward, complaining of abdominal pain and her abdomen remained distended. As the respondents noted:

After Ms Podio was transferred out of the DST Ward, Sister Switzer contacted Ms

Fawdry, (the matron), three times over a couple of hours about the seriousness of Ms Podio's condition: Switzer pg. 35-36 (CB11 HN0143). Ms Fawdry called Dr Bailey and he told her to contact Dr Gill: Fawdry XIC T1502.13-22. Ms Fawdry then called Dr Gill and asked him to come and have a look at Ms Podio: Fawdry XIC T1502.24-25. Following her call to Ms Fawdry, Sister Switzer received a call from Dr Gill who told her that she was not to keep bothering Ms Fawdry, Ms Podio was alright, and that Sister Switzer should not be making such a fuss and if she continued to do so it would be better if she did not work there: Switzer pg. 36-37 (CB11 HN0143).

During cross-examination, Dr Gill had no memory of being telephoned by Ms Fawdry and denied calling Sister Switzer regarding Ms Podio: Gill XXN T252.17-39, 255.28-30. For the reasons given above, the Court should not accept that evidence. In any case, Ms Fawdry has a clear recollection of calling Dr Gill to request that he see Ms Podio, her evidence should be accepted. Sister Switzer's evidence regarding the call she received from Dr Gill was consistent (Switzer pg. 35-36, 41-43, 93-94, 99 (CB11 HN0143)).

535 I accept these submissions. The evidence of Ms Fawdry and nurse Switzer was consistent. Dr Gill's contrary recollections are not to be trusted.

536 Despite all this, Mr Herron gave Ms Podio ECT on 10 and 11 August 1977 with anaesthetic: MED00056.7-8 (RTB6); MED00058.6 (RTB6). Dr Bailey also examined Ms Podio on 10 August 1977 and ordered that she be given a high olive oil enema: MED00056.7 (RTB6), MED00059.17 (RTB6). Dr Gill examined Ms Podio on 11 August 1977 and directed that she be given Epsom salts, which occurred at 6pm that night: MED00059.23-24 (RTB6). At this stage Ms Podio was in abdominal distress and she looked moribund: MED00059.22, 19 (RTB6), Fawdry examination in chief (XIC) at T1503.12-19 and XXN at T2152.14-26. It is not apparent why the treating doctors, including Dr Gill, did not arrange for Ms Podio to be immediately transferred to a general hospital given her continuing symptoms of abdominal distress.

537 To continue in accordance with the respondents' submissions:

In the evening of 11 August 1977, Ms Podio was visited at Chelmsford by her mother and her neighbour who expressed shock and concern about her condition: MED00059.24 (RTB6); Switzer pg. 37 (CB11 HN0143). That night Ms Podio continued to be confused, vomited bile fluid, fell over and was incontinent of faeces: MED00058.35 (RTB6); MED00059.25 (RTB6). Accordingly, she was moved to the DST Ward for closer observation: MED00059.25 (RTB6).

538 Thereafter:

According to the nurses' records (at MED00059.25-26 and MED00058.35, RTB6), at about 6.25am on 12 August 1977, Miss Podio [sic] had a respiratory and cardiac arrest. She was immediately placed on the floor, her airway cleared, external cardiac massage was commenced and oxygen with manual respirator was administered. Within 3 minutes of the respiratory and cardiac arrest, Dr S Merzliakov was contacted. He arrived at Chelmsford 15 minutes after he was contacted. Dr Merzliakov examined Ms

Podio on arrival and found no vital signs so resuscitation ceased.

539 As noted, Dr Smith considered that Ms Podio's death was caused by the DST administered, the abdominal obstruction being the most likely precise cause of death. He said in oral evidence that he considered this to be so having regard to:

That she had the blood pressure falling, there was evidence of gross distension of the abdomen, some bowel sounds, aspiration and vomiting of dark fluid and melena [sic] stools, all of which would not be occurring in the normal person. So I attributed it to the treatment she was receiving at that time.

540 As noted, the melaena stool was mentioned by Dr Smith but was not critical to his conclusions.

541 Dr Phillips' evidence is that the increasing severity of Ms Podio's symptoms meant that normally ECT would not have been given: EXP00012.11 [11] (RTB1). Mr Herron, however, gave her ECT twice when it was or should have been apparent that Ms Podio was very unwell. The fact that Dr Bailey had ordered the ECT is no excuse for Mr Herron administering ECT to such an apparently unwell patient. There is no evidence Mr Herron considered Ms Podio's condition before giving her ECT. There is no evidence he read the nursing notes (which seems to have been standard, albeit unacceptable, practice for Mr Herron). Had he conducted an examination of her and discussed her condition with the nurses before administering ECT it would reasonably be expected that Mr Herron would have decided that Ms Podio should be transferred to a general hospital for care given that the treatments administered by Dr Bailey and Dr Gill had proved to be ineffective. Again, not conducting any form of physical examination of a patient before giving them ECT also appears to have been Mr Herron's standard, albeit unacceptable, practice. As the physician giving Ms Podio ECT it was Mr Herron's responsibility to ensure that she was well enough to receive that treatment. He grossly failed in his duty of care to Ms Podio.

542 Mr Herron gave this evidence:

Can I suggest this to you, that had you read the nurse's notes that I've taken you to and found out about what had occurred to Ms Podio – and I pause there to say the reference to the melena [sic] stools, the abdominal distress, the fact that her abdomen was distended; I suggest to you that, had you read the nurses notes and found out – read those things, you should have immediately arranged for the transfer of Ms Podio to a general hospital?---And I would agree.

543 Further, as the respondents submitted:

When Mr Herron gave Ms Podio ECT on 10 and 11 August he did not use a muscle relaxant: MED00058.6 (RTB6). The reason that Mr Herron gave for not using muscle relaxant on DST patients was their level of sedation: Herron 2 [51] (RTB2 AFF000F, pg. 11). Given that Ms Podio had been lightened from sedation, there was no reason

not to use a muscle relaxant, and proper medical practice required it: Smith Report [4] (CB2 REP0001, pg. 5); Phillips Report [151] (CB2 REP0012, pg. 28); EXP00012.9 [C(2)] (RTB1).

544 The applicants' submissions about Ms Podio are unpersuasive. It does not matter that she had an extensive psychiatric history before her admission to Chelmsford. DST was not indicated for any such condition. It is not accurate to say that Ms Podio's observations were normal when she was very mucousy and aspirating dark coloured fluid with a foul odour from her mouth. The applicants' theory about nurse Switzer having a motive to embellish her evidence is nothing but speculation. The history of Ms Podio's symptoms throughout her treatment are consistent with nurse Switzer's evidence.

### **7.5.5 Janice Nam**

545 Ms Nam, aged 35, died while DST was being administered at Chelmsford.

546 Dr Greenaway provided a report to the Royal Commission about her death. She was a patient of Dr Bailey. He considered her treatment at Chelmsford including ECT as "most certainly...inappropriate". He said that assuming Mr Nam's account of his wife's condition was correct then ECT "would have been running a grave risk of being positively harmful". There is no reason to accept the applicants' criticisms of Dr Greenaway's report. His report is evidence that Ms Nam was treated with DST. It is evidence that she was experiencing symptoms which contraindicated DST and ECT. Mr Herron administered ECT to Ms Nam on 17 and 18 April 1972. Mr Herron was under a duty to ensure that any patient to whom he administered ECT was sufficiently well to be given ECT. Dr Greenaway had the benefit of information not in evidence in this proceeding. There is no reason, however, to infer that Dr Greenaway was doing other than giving his objective opinion based on the material with which he had been provided. The fact that Dr Greenaway is not available for cross-examination may be accepted, but this is an insufficient reason to discount the effect of his evidence.

### **7.5.6 Other patients**

547 Contrary to the applicants' submissions, the report of Dr Gandevia is evidence that the patients listed in his table 1, excluding patients 7, 14 and 18, died in circumstances where there was a direct relationship between the death and the administration of DST. This includes:

- (1) Hector Crampton (aged 64);
- (2) Thomas Cameron (aged 22) to whom Mr Herron gave ECT;

- (3) George Neave (aged 68) (whom Dr Joseph concluded developed pneumonia during DST and that DST materially contributed to his death);
- (4) Reginald Atkinson (aged 53) to whom Mr Herron gave ECT;
- (5) Kelvin Kingston (aged 45) for whom Mr Herron prescribed antibiotics;
- (6) Arnold St Clair (aged 49) to whom Mr Herron gave ECT;
- (7) Ann Bennett (aged 35) (whom Dr Joseph said most likely drowned in her own secretions given she was unconscious from the start of DST, was very mucousy, had a rapid respiratory rate and a rapid pulse rate and became cyanosed, and opined that DST was the primary cause of her death);
- (8) Stavroula Leousis (aged 40) (whom Dr Joseph said died under DST and within 48 hours of ECT being given. He noted that he was of the opinion that DST in such a grossly obese patient was inherently dangerous and led to the pneumonic condition which caused her death);
- (9) Theresa Howell (aged 61); and
- (10) Ronald Carter (aged 23).

## 7.6 Barry Hart

548 Mr Hart died relatively recently. The respondents relied on Mr Hart's evidence to the Royal Commission.

549 The applicants' submissions about Mr Hart are unbalanced and implausible. They accuse Mr Hart of being a liar and the perpetrator of a false narrative responsible for the adverse complaints, media coverage, political lobbying, investigations and proceedings about Chelmsford that followed. They describe him as "a dissatisfied person who blames others for his own dissatisfaction rather than blaming fate or himself", "a dishonest narcissist and/or a paranoid fantasist", a person who had "deliberately manufactured that evidence to give the impression that ECT (and consequently DST) was not an appropriate treatment", in circumstances where there was "much to be said with the benefit of hindsight that the treatment Mr Hart received at CPH [Chelmsford] in March 1973 saved and improved his life – Mr Hart died in old age in March 2019".

550 It is difficult to escape the conclusion that the vociferousness of the applicants' submissions against Mr Hart reflect a deep personal animosity that the applicants hold for him given that Mr Herron was held liable for assault, battery and false imprisonment of Mr Hart: *Hart v*



*Herron*. As the respondents noted, Mr Herron gave evidence before the Royal Commission that *Hart v Herron* had a devastating effect on his professional and domestic life, such that his practice as a psychiatrist had dwindled. I also accept the respondents' submission about Mr Herron's deeply held loathing of Mr Hart. As the respondents put it:

Mr Herron grossly downplayed Mr Hart's suffering, even in the face of expert evidence that Mr Hart was close to death on his discharge from Chelmsford: Herron XXN at T2517. He quibbled with the diagnosis of serious physical ailments made by the doctors at Hornsby Hospital, even to the point of refusing to admit that Mr Hart was transferred there in an emergency situation: Herron XXN at T2516. Extraordinarily he claimed that the pneumonia that developed in Mr Hart's lungs as a result of the treatment administered by him was somehow worsened by Mr Hart's own hysterical response to it: Herron XXN at T2513.32-4. Mr Herron even suggested, despite incontrovertible evidence that Mr Hart suffered serious short and long term consequences from the treatment, that Mr Hart's treatment at Chelmsford did him very well: Herron XXN at T2512.47. It's unsurprising that Mr Herron despises Mr Hart. Mr Hart was successful in his proceedings, and his efforts were instrumental in bringing about the Royal Commission. Mr Herron has admitted that those events ruined his career: Ex. 49, Tab 1 para [61]. In these circumstances Mr Herron's evidence regarding Mr Hart is so obviously coloured by animus that it must be rejected.

551 As I have said, the same animus against Mr Hart infects the applicants' submissions about virtually all aspects of Mr Hart's experience at Chelmsford and its long-term impact on him. Some examples will suffice as sufficient reason not to give those submissions credence.

552 The fact that Mr Hart was suffering psychological distress over what he perceived to be a botched eye operation at the time that he first saw Mr Herron may be accepted. Neither this fact nor Mr Herron's assessment of him as possibly obsessive and a touch paranoid means that Mr Hart was a fantasist when it came to describing what happened to him at Chelmsford. Mr Herron prescribed an anti-depressant and anti-psychotic. The fact that Mr Hart commenced proceedings against the surgeon who conducted the eye surgery also does not tend to undermine Mr Hart's credit as a witness.

553 The note Mr Herron made on 26 February 1973 (*Barry Hart, new admission himself coming in tomorrow or next day – depressed in for sedation* (APP116.1)) does not prove that Mr Herron explained to Mr Hart the details and risks associated with DST. As I have said before, given that a proper explanation would have included the real risk of death and serious complications, I find it inherently unlikely that Mr Herron explained anything to Mr Hart other than that he would be admitted to Chelmsford for treatment. Mr Hart said that he had a call with Mr Herron before his admission in which no details of the proposed treatment were explained to him. He also recalled on admission to Chelmsford specifically stating that he did not want to receive

ECT. As the respondents point out, the evidence of Mr Dilworth, a nurse on whom the applicants rely, does not directly contradict Mr Hart's evidence. Specifically:

Mr Dilworth's evidence in chief in *Hart v Herron* was that he had told Mr Hart that he may have ECT if necessary as decided by the doctor: Dilworth pg. 9 (CB4 HN000C). However in cross-examination in those proceedings Mr Dilworth admitted that this was his usual practice for DST patients, but couldn't swear that he had actually said that to Mr Hart: Dilworth pg. 32 (CB4 HN000C). He then repeated during his evidence at the Royal Commission that he could not swear that he advised Mr Hart that he would be receiving ECT Dilworth pg. 15 (CB5 HN0032). Mr Dilworth's evidence goes no higher than that of his regular practice with patients at Chelmsford. There is no evidence of a direct recollection of what he said to Mr Hart. Insofar that it is necessary to weigh the evidence of Mr Dilworth against Mr Hart's, it is clearly Mr Hart's evidence (which is an unwavering and a direct recollection) than Mr Dilworth's 'regular practice' evidence.

554 In these circumstances, the applicants' reliance on selective aspects of the evidence of Mr Dilworth is misplaced.

555 In these circumstances it cannot be said that Mr Hart presented himself at Chelmsford "for deep sedation". Whether or not Mr Hart was suicidal before his admission need not be decided. He was certainly anxious and depressed and seeking professional assistance. I find Mr Herron's evidence in this proceeding that he explained sedation to Mr Hart and the need for ECT as well as the serious risks associated with DST self-serving and inherently unlikely. The idea that Mr Hart would willingly present himself for a treatment with a serious risk of death stretches the bounds of credulity. The idea that he would be willing to attend for ECT when he was adamant on arrival that he would not consent to ECT is also far-fetched. Mr Hart's version of events is far more plausible. Mr Herron simply told him that he would put him in Chelmsford for a few weeks to get rid of his depression. It is not unlikely that a layperson such as Mr Hart would not demand detailed information from Mr Herron about the proposed treatment. Mr Hart could not have known that Mr Herron was going to subject him to an outmoded experimental treatment for which there was no medical justification and which carried with it a serious risk of harm and death. Had he known that, it is profoundly unlikely that Mr Hart would have gone anywhere near Chelmsford, let alone present himself for admission for a few weeks in-patient treatment to deal with his depression. The applicants' characterisation of Mr Hart as a "professional and obsessive patient" is demeaning and unfounded. There is evidence that he was obsessive about his appearance (he was an actor and considered his appearance critical to his work) but that does not mean he was obsessive about obtaining details of proposed psychiatric treatment which he assumed would help him.

556 To describe Mr Hart's experience at Chelmsford with the statement that he became sick and  
was transferred to Hornsby Hospital is unjustifiably dismissive of his actual experience as  
consistently reported.

557 For one thing, it is clear from the evidence that Mr Hart never signed a consent form for ECT.  
As the respondents noted:

Dr Gill admitted during cross examination that Mr Hart did not sign a consent form for  
the ECT he received at Chelmsford: Gill XXN at T308.20-1. Somewhat puzzlingly Mr  
Herron refused to accept that Mr Hart did not sign his consent form: Herron XXN at  
T2488.26-8, however did so during his evidence at the Royal Commission: Ex. 48,  
Tab 13, pg. 1354-5. Considering Dr Gill's admission, Mr Hart's evidence, and the fact  
that Mr Hart's form was cut to remove the consent section, the Court can be satisfied  
that Mr Hart did not sign a consent form for ECT. This tells against the proposition  
that Mr Hart provided oral consent. If Mr Hart was willing to give oral consent, then  
there was no reason to not get the consent form signed.

558 The expert evidence was also clear. In accordance with accepted professional practice at the  
time written consent to both DST and ECT was required. As the respondents submitted:

- (1) Professor Parker referred to the need for written consent for a procedure such as ECT,  
saying written consent was a long-established procedure at the time; and
- (2) Dr Smith said that written consent for both ECT and DST was mandatory at the time  
that those treatments were delivered to Mr Hart.

559 On the evidence, Mr Hart consented to neither DST nor ECT.

560 A digression about some evidence of Ms Fawdry is necessary. Contrary to the applicants'  
submissions about the form for Mr Hart which had the bottom cut off (where the consent to  
ECT with a place for a signature appeared cut off and replaced by a copy of another form), I  
find Ms Fawdry's evidence to this Court wholly believable. She said that in about 1978 she  
was involved in a meeting with Dr Gill, Mr Herron and Ms Sansom where it was discussed  
how the fact that Mr Hart's ECT form was not signed could be disguised. Someone suggested  
that they could put a pathology paper over the top of it to disguise the fact that the form was  
not signed. Ms Fawdry's evidence that she had not previously been frank in her dealings with  
police and others about her knowledge of this meeting due to fear for her nursing registration  
made sense. The applicants' convoluted attempts to dismiss or explain away Ms Fawdry's  
evidence are unconvincing. Having seen and heard Ms Fawdry's evidence I have no doubt she  
was telling the truth about the meeting in the Royal Commission and in this proceeding.

561 As I have said, I find Mr Herron's evidence that his ordinary practice was to inform patients of the risk of death from DST inherently unbelievable. Patients would not have presented for treatment over years had they truly been informed of the actual mortality rate or rate of serious complications of DST at Chelmsford and the other alternatives available which would have been necessary to enable the patient to give informed consent. It is not apparent that Chelmsford maintained records of its rates of mortality and serious complications from DST; as such, how any patient could have been given sufficient information to provide informed consent is not apparent. The hospital was permitting an outmoded experimental and highly dangerous procedure to be inflicted on vulnerable patients with no apparent regard for the kind of safeguards the experts mentioned as necessary in terms of responses to adverse events (and the deaths directly relatable to DST at Chelmsford were adverse events of the most serious kind). It cannot be accepted that practitioners involved in such cavalier and abusive conduct towards their patients would have seen it as necessary to provide their patients with the information they needed to make a fully informed decision about involvement with this treatment.

562 As the respondents observed, the inference that I draw, that Mr Herron did not give Mr Hart any details about his proposed treatment at Chelmsford, is consistent with other evidence. Specifically:

- (1) several patients of Mr Herron gave evidence at the Royal Commission directly contradicting Mr Herron's evidence, in that they were not informed of the side-effects or risks of DST, or sufficient detail of the treatment, prior to receiving it; and
- (2) nurse Bothman said that she observed many patients arriving for DST at Chelmsford who did not know what their treatment would entail: affidavit of Julie Bothman dated 18 March 2020 [163]-[174] (CB2 AFF0001 pp 33-5).

563 The applicants' attempts to discredit the former patients as liars, who were effectively involved in a conspiracy with Scientologists to discredit Chelmsford and the applicants, and who should be disbelieved because of their psychiatric conditions are far-fetched. The far more likely explanation of the inconsistency between their evidence and that of Mr Herron is that Mr Herron (and Dr Gill) firmly believe that they were done a serious wrong by the Royal Commission, the Scientologists and their former patients, and nothing will persuade them to the contrary. It is apparent that their lives since have involved a consistent attempt to justify their actions in their own minds and to others. Their evidence largely reflects their strong desire for justification and exculpation.

564 I accept Mr Hart's evidence that he did not give consent to DST or ECT at Chelmsford. However, as the respondents noted, notwithstanding the absence of consent from Mr Hart:

- (a) at 5pm on 28 February 1973, Mr Hart was given two tablets of Mylodorm and at 6.15pm, DST commenced by way of a 500mg injection of Sodium Amytal (Ex. 44, pg. 2, 14);
- (b) Mr Hart was kept sedated for the next 10 days by the continued administration of Tuinal (Ex. 44, pg.16-17); and
- (c) between 28 February and 9 March 1973, Mr Hart was administered ECT 6 times (Ex. 44, pg. 14).

565 Nothing in the applicants' submissions about Mr Hart's dissatisfaction with various doctors and lawyers supports the submission that he was "a dishonest narcissist and/or a paranoid fantasist". Whatever Mr Hart's tendency to blame others apparent in his reaction to his eye surgery and his legal representation, it does not alter the fact that it is inherently improbable that he consented to a treatment that he had been told involved a serious risk of harm and death.

566 The fact that there are discrepancies in Mr Hart's recollection, far from undermining his credibility, lend weight to the substantial veracity of his evidence. For example, while Mr Hart thinks he was presented with a form seeking consent for "shock treatment" which he refused to sign, the Chelmsford form referred to ECT. This does not mean Mr Hart was giving false evidence. It means that his recollection was inaccurate in respect of the description of ECT on the form. It would not be surprising if a layperson, if told about ECT on arrival at Chelmsford, would believe that they had refused to sign a form referring to "shock treatment". That is a common lay description of ECT. His evidence that he was given some tablets to calm him down is consistent with the evidence of him being given the barbiturate Mylodorm. His evidence that he cannot recall anything thereafter is described by the applicants as another false narrative. Mr Hart may be misremembering the nurse involved, but this does not mean that his broad description of events is inaccurate. The fact that, after being placed in a coma by DST, he did not recall the taking of his temperature, pulse, respiration, blood pressure, or weight does not make him a liar. It makes him a person who had an incomplete recollection of apparently unimportant details. Further, the fact that a person who had been deeply sedated for a lengthy period may not recall the details of his injection with sodium amytal and transfer to the DST ward is unsurprising. Mr Herron saying he was told that Mr Hart agreed to have the treatment and got into bed of his own volition is self-serving and may be discounted. There is no reason to think that Mr Hart, who consistently maintained that he never consented to DST or ECT, was doing other than telling the truth about these essential facts.

567 As the respondents submitted:

There are two elements to the tort of false imprisonment. First, subjecting another to a total restraint of movement by either causing that person's confinement or preventing that person from leaving the place in which he or she is. Second, that restraint is against the person's will.

568 The DST administered by Mr Herron to Mr Hart rendered him unconscious. His sedation commenced on 28 February 1973 and continued for 10 days by regular administration of Tuinal. He was so deeply sedated that he was fed through a naso-gastric tube and was incontinent. As the respondents submitted:

Dr Smith opined that the quantities of barbiturates administered to Mr Hart induced a coma: Smith Report (Appendix 1) pg. 4 (CB4 REP0003). Professor Whyte agreed (albeit in relation to the Chelmsford drug regime generally, not Mr Hart specifically), stating that the daily doses of barbiturates administered to DST patients at Chelmsford would render an average adult, non-tolerant patient comatose: Whyte Report [274]-[277] (CB4 REP0004).

569 It is plain that through his administration of DST to Mr Hart, Mr Herron subjected Mr Hart to a total restraint of movement and prevented Mr Hart from leaving Chelmsford. The fact that this was done to Mr Hart without his consent means that Mr Herron falsely imprisoned Mr Hart during his DST at Chelmsford.

570 Whatever his psychological condition on admission to Chelmsford there is no material contradicting Mr Hart's evidence that he was in peak physical condition on his admission – as well as acting, he ran a gymnasium and was a part time model. There is good reason to believe that at the time he was far fitter than the average person, as he said, given his reported level of physical activity. He was 37 years old and weighed 14 stone 5 pounds and was 6 feet 2 inches tall. All his observations on admission were normal.

571 Mr Hart suffered a series of complications during the administration of DST, none of them unexpected given the dangerous nature of the treatment and its known suite of complications. As the respondents submitted the nursing records show that:

During Mr Hart's period of sedation at Chelmsford, he suffered from cyanosis and cyanosed extremities on 2 March 1973 (Ex. 44, pg. 3-4). He suffered distressed breathing that required the administration of oxygen on 2 March 1973 (Ex. 44, pg. 3). Mr Hart also suffered tachycardia at the time: Ex. 44, pg. 3 and EXP00012.16 (RTB1). By the 18th, Mr Hart was still suffering from respiratory distress as his respiration rate rose to at least 48 (Ex. 44, pg. 20), and may later have risen to 52 breaths per minute. That is what Ex. 44, pg. 20) [sic], appears to show, although the Respondents accept that the nurse's handwriting is not entirely clear (see T1930).

Mr Hart had an elevated body temperature for long periods during his sedation. On the evening report of 2 March 1973, Mr Hart exhibited a temperature of 39 degrees (Ex.

44, pg. 4). On 3 March 1973, Mr Hart exhibited a temperature of 38.2 degrees during the day shift and 38.5 degrees during the evening shift (Ex. 44, pg. 5). On 4 March 1973, his temperature remained elevated during the day report and was 37.6 degrees in the night report (Ex. 44, pg. 6). On the evening report of 5 March 1973, Mr Hart exhibited a temperature of 38.2 degrees (Ex. 44, pg. 7). On the evening report of 10 March 1973, he had a temperature of 38.5 degrees (Ex. 44, pg. 11). Even a rise in temperature to 37.6 was a grave warning sign in anyone in a coma, according to Dr Smith: Smith XXN at T1920.39.

In addition to his elevated body temperature, Mr Hart suffered from urinary incontinence on 6, 8, 9 and 10 March 1973 (Ex. 44, pg. 7, 9, 10). He was medically unwell for the greater part of his time spent at Chelmsford: EXP00012.15 (RTB1).

572 It is apparent that Mr Hart was unwell from almost the beginning of DST. As the respondents said:

Mr Herron attended on Mr Hart to administer ECT on 28 February, 4, 6, 7 and 9 March 1973: Ex. 44, pg. 3, 6, 8, 10. In addition to this, Mr Herron was notified of Mr Hart's tremulous and cyanotic condition and attended on Mr Hart at 1.30am on 3 March 1973 (Ex. 44, pg. 4). Not only was Mr Herron the treating doctor, he attended Chelmsford almost every day and had ample opportunity to respond appropriately to what were serious medical complications. In fact as early as 10 March 1973 Mr Herron had diagnosed Mr Hart with pneumonia: Herron XXN at T2505. Despite all of this, Mr Herron stubbornly maintained DST at Chelmsford for approximately 2 weeks.

573 The evidence of Dr Smith and Dr Phillips, which I accept, was to the following effect:

- (a) Mr Hart should, at the very least, have been seen by a consultant physician on 2nd March 1973 to determine the cause of his chest infection. Ideally Mr Hart should have had his sedation treatment ceased (which would have complicated any chest infection) and been moved to Hornsby Hospital at that date for appropriate observation, investigation and treatment: EXP00012.16 (RTB1) and Smith Report (Appendix 1) (CB3 REP0003, pg. 4);
- (b) Mr Herron should not have treated Mr Hart with ECT in circumstances where he was febrile and ill; ECT should only have been delivered in a patient in these circumstances if it is considered a life-saving procedure: EXP00012.16 (RTB1) and Smith Report (Appendix 1) (CB3 REP0003, pg. 5);
- (c) Mr Herron should have ordered a chest x-ray and sputum culture when Mr Hart started to develop an illness: EXP00012.15-6 (RTB1) and Smith Report (Appendix 1) (CB3 REP0003, pg. 5);
- (d) Mr Hart should have undergone a thorough physical examination and chest x-ray prior to commencing treatment: Smith Report (Appendix 1) (CB3 REP0003, pg. 4)
- (e) Mr Hart was delivered barbiturate drugs in quantities far exceeding the treatment sheet, which was a failing on Mr Herron's part to properly supervise the nursing staff: Smith Report (Appendix 1) (CB3 REP0003, pg. 4);
- (f) Mr Hart should have been nursed in an ICU ward: Smith Report (Appendix 1) (CB3 REP0003, pg. 4);
- (g) Mr Hart did not have his fluid intake and output properly monitored: Smith Report (Appendix 1) (CB3 REP0003, pg. 4);

- (h) Mr Herron gave ECT to Mr Hart without either muscle relaxant or anaesthetic: Smith Report (Appendix 1) (CB3 REP0003, pg. 4); and
- (i) Mr Herron should have ensured that Mr Hart was nursed in such a way as to avoid DVT: Smith Report (Appendix 1) (CB3 REP0003, pg. 4).

574 As the respondents put it, Mr Hart's description of his emergence from DST is harrowing. There is no reason to disbelieve his evidence. When he was sedated it was as if he had a mind but no body and two beams of light exploded in his head. As he came around 10 days later everything was black. He had tremendous pain in his shoulders. He could not move his arms as they were strapped to the bed. He screamed to get the straps off. He recalled screaming by a woman and then periods of consciousness. He recalls his throat being full of choking mucous. He could not open his eyes as the light was too bright. He was hallucinating. He felt violently ill and vomited including vomiting blood. He had excruciating chest pain like a knife being twisted into his ribs. He tried not to breathe to ease the pain. He was concerned about whether he would live. He was unable to move his limbs and felt paralysed.

575 Mr Hart's medical records are consistent with his recollections:

- (a) On 11 March 1973, Mr Hart was hallucinating with poor focus and nausea;
- (b) On 13 March 1973, Mr Hart is recorded as suffering severe pain in his chest;
- (c) On 14 March 1973, Mr Hart was taken for a chest x-ray, which revealed broncho pneumonia;
- (d) On 15 March 1973, it was recorded that Mr Hart had blood stained sputum and continued to be in pain; and
- (e) By the 18th and 19th of March, Mr Hart is recorded as coughing and vomiting blood on three occasions and continuing to be nauseous and in pain.

576 There is no merit to any suggestion that Mr Hart was exaggerating his dire condition. He was so ill Chelmsford transferred him to Hornsby Hospital after a week in the Chelmsford general ward. The Hornsby Hospital notes show that on admission he presented with pleurisy and was diagnosed as suffering bilateral bronchopneumonia and a pulmonary embolus: a blood clot likely caused by deep vein thrombosis (**DVT**) travelling from the leg to the lungs: MED00096.1 (RTB7); expert report of Dr Smith (Appendix 1) (CB3 REP0003, pp 3-4).

577 The applicants submitted that:

Patients under sedation, coming out of sedation, under medication or even just spending time in a hospital may have hallucinations and other experiences that may be unusual but are the ordinary benign side-effects of those treatments. No responsibility can be properly attributed to treating healthcare practitioners for these experiences. Those doctors and nurses are not responsible for a patient's unique fixation on these



experiences or false memories that may have accrued over time.

578 I disagree. Subjecting a patient (who is already psychologically vulnerable) to treatment which induces serious and disturbing (potentially traumatising) hallucinations is not a benign side effect. The doctors who prescribed the treatment are responsible for the known side effects of the treatment. Mr Hart, like other patients, knew he was suffering from hallucinations. This does not change the fact that the process of coming out of sedation was so traumatic and he was so ill and in such pain that he feared for his life in Chelmsford.

579 It is not inconceivable or even surprising that in his dire condition on admission to Hornsby Hospital Mr Hart said nothing then about having been sedated against his will. Mr Hart lost 9kgs while in Chelmsford which, contrary to the applicants' submissions, is a significant weight loss (nearly 1 and a half stone) and not so far from the 2 stone weight loss to which Mr Hart later referred. He was seriously ill on admission to Hornsby Hospital. It might be inferred that his focus at the time was on his survival and health, not what had been done to him at Chelmsford. Accordingly, I reject the applicants' submission that:

...given his subsequent complaints and his complaints recorded in the history it is inconceivable he would not have made that complaint at that time if he had not consented to deep sedation treatment that had resulted in his transfer to Hornsby.

580 The applicant's denial of a diagnosis of DVT at Hornsby Hospital is typical of their tendentious approach to the evidence. The fact is on his discharge summary from Hornsby Hospital there is a diagnosis of pulmonary embolus, a well-known complication involved in DST. The suggestion that he was treated for pulmonary embolus because he would have been a difficult patient may be dismissed as fanciful. He was no doubt treated for pulmonary embolus because the doctors at Hornsby decided he was suffering from that condition.

581 Dr Smith considered that on his transfer to Hornsby Hospital Mr Hart had a 50% chance of survival given he was suffering from bronchopneumonia and pulmonary embolus: Smith RXN at T1950.10. Both of these conditions were caused by the treatment Mr Hart received at Chelmsford: Smith Report (Appendix 1) (CB3 REP0003, pp 4-5). Mr Herron's treatment of Mr Hart had the effect of nearly killing him with some of the well-known serious complications of DST.

582 As the respondents submitted:

On any view, the treatment meted out to Mr Hart would strike an ordinary reasonable reader as grossly negligent, in the ordinary English meaning of that term. In circumstances where a treatment almost kills a patient that has been admitted to

hospital in peak physical condition... that is what an ordinary person would think. Taking that further, there is universal agreement between the medical experts in these proceedings that DST should never have been administered to patients at Chelmsford ... DST was an outdated and incredibly dangerous treatment without any benefits. The corollary of this is that any complication caused, or contributed to, by DST is necessarily the result of gross negligence by the treating doctor.

583 Dr Smith is the only expert who gave evidence in this matter who assessed Mr Hart after his admission to Chelmsford. As noted, he interviewed Mr Hart for four and a half hours. On this basis Dr Smith was well placed and well qualified to opine about Mr Hart's ongoing problems. Dr Smith considered that as a direct consequence of the DST treatment Mr Hart received, "he suffered anoxic brain damage with cognitive changes and a personality change": Smith Report (CB2 REP0001, p 8). As discussed above, I reject the applicants' criticisms of Dr Smith. As the respondents pointed out:

The Court is able to rely on this evidence from Dr Smith. Dr Smith is a qualified expert, who properly formed a medical opinion about a fact 40 years ago, and he remains of that opinion. He has divulged the basis on which that opinion was formed. It was open to the Applicants to ask any questions they liked about those recollections, including the various detailed matters about Mr Hart now set out in their written submissions. It was open to the Applicants to put to Dr Smith that there have been matters in the interim that should have changed his opinion. In the unique circumstances of this case, the Court can take into account Dr Smith's historical opinion (as repeated by Dr Smith in this Court) to conclude that Mr Hart suffered anoxic brain damage.

If the Court is satisfied that Dr Smith is an expert, then respectfully it can also be satisfied that any opinion he formed about a patient based on a four and a half hour interview with them is valid and should be accepted, irrespective of how long ago those opinions were formed. The Applicants complaints in this respect are spurious.

584 Mr Hart subsequently said that as a result of his experiences at Chelmsford he suffered chronic post-traumatic stress disorder involving flashbacks, heightened startle response, nightmares, panic attacks, and situation anxiety. There is no reason not to accept Mr Hart's description of the long-term effects Chelmsford had on him. The harm to which he was subjected was of a kind inherently likely to involve serious long-term adverse consequences. It should be no surprise that Mr Hart described those consequences in such graphic terms.

585 The fact that Mr Hart was able to make a life after Chelmsford, including continuing his acting career and management of his gym business, does not mean that he did not suffer from long-term effects from his treatment at Chelmsford. The submission that the treatment he received at Chelmsford was beneficial and he should have been grateful is self-serving in the extreme.

## 8. DEFAMATORY MEANING

### 8.1 Principles

586 There was no dispute between the parties as to the applicable principles.

587 The applicants referred to *Rush v Nationwide News Pty Ltd (No 7)* [2019] FCA 496 (***Rush (No 7)***) and summarised the applicable principles in these terms:

- (1) whether or not the matter conveys defamatory meanings is determined from the perspective of the “ordinary reasonable reader”. This hypothetical individual is a person of fair average intelligence, not avid for scandal but equally, prone to a degree of loose thinking and capable of reading between the lines: at [74]-[77];
- (2) the meaning that an ordinary reasonable reader would attribute to the matter may be influenced by its overall tone or tenor. A publication which employs loose language or indulges in innuendo or speculation may convey a defamatory imputation more readily than one which is more carefully written and neutral in tone: at [80]; and
- (3) the publisher’s intended meaning, and the meaning actually understood by individual readers of the matter complained of, are irrelevant: at [84]-[85].

588 The applicants observed further as follows:

- (1) the natural and ordinary meaning of defamatory matter includes any implication or inference which an ordinary reasonable reader would derive from the matter, guided by general knowledge and unfettered by strict legal rules of construction: *Jones v Skelton* [1963] 1 WLR 1362 at 1371 per Lord Morris;
- (2) defamatory imputations can be derived even from apparently innocuous words by implication or inference: *Favell v Queensland Newspapers Pty Ltd* [2005] HCA 52; (2005) 79 ALJR 1716 at [14]-[18]; and
- (3) defamatory matter must be read as a whole, and the imputations pleaded are to be construed in the context of the entire matter: *Australian Broadcasting Corporation v Chau Chak Wing* [2019] FCAFC 125; (2019) 271 FCR 632 at [168]-[171] (***Chau Chak Wing***); *Greek Herald Pty Ltd v Nikolopoulos* [2002] NSWCA 41; (2002) 54 NSWLR 165 at [18]-[27] per Mason P.

589 The applicants also identified the principles applicable to the question whether the imputations, if conveyed, are defamatory, observing that matter is defamatory if it carries a meaning about

the applicant which is calculated to expose him or her to hatred, contempt, or ridicule; lower him or her in the estimation of ordinary right-thinking members of society; or cause others to shun and avoid him or her: *Boyd v Mirror Newspapers Ltd* [1980] 2 NSWLR 449 at 452 per Hunt J; *Mirror Newspapers v World Hosts* [1979] HCA 3; (1979) 141 CLR 632 at 638; *Radio 2UE v Chesterton* [2009] HCA 16; (2009) 238 CLR 460 at [5]; *Rush (No 7)* at [67].

590 The respondents stressed that questions of meaning are to be determined objectively by reference to the hypothetical construct of the “ordinary reasonable reader”. It is the “ordinary reasonable reader” who gleans the “natural and ordinary meaning” of the publication and determines whether that meaning is defamatory: *Trkulja v Google LLC* [2018] HCA 25; (2018) 263 CLR 149 at [31] and [32], *Chau v Fairfax Media Publications Pty Ltd* [2019] FCA 185 (*Chau*) at [14], and *Hockey v Fairfax Media Publications Pty Ltd* [2015] FCA 652; (2015) 237 FCR 33 (*Hockey*) at [63]-[69].

591 The respondents referred to the observations of Brennan J in *Readers Digest Services Pty Limited v Lamb* [1982] HCA 4; (1982) 150 CLR 500 at 505 that:

...the issue of libel or no libel can be determined by asking whether hypothetical referees - Lord Selborne’s reasonable men ... or Lord Atkin’s right thinking members of society generally ... or Lord Reid’s ordinary men not avid for scandal ... - would understand the published words in a defamatory sense. That simple question embraces two elements of the cause of action: the meaning of the words used (the imputation) and the defamatory character of the imputation. Whether the alleged libel is established depends upon the understanding of the hypothetical referees who are taken to have a uniform view of the meaning of the language used, and upon the standards, moral or social, by which they evaluate the imputation they understand to have been made. They are taken to share a moral or social standard by which to judge the defamatory character of that imputation, being a standard common to society generally.

592 By reference to *Amalgamated Television Services Pty Ltd v Marsden* (1998) 43 NSWLR 158 at 165, *Farquhar v Bottom* [1980] 2 NSWLR 380 at 386-387, and *Radio 2UE Sydney Pty Ltd v Chesterton* [2009] HCA 16; (2009) 238 CLR 460 at [1]-[7], the respondents identified the attributes of the hypothetical “ordinary reasonable reader” as that he or she:

- (a) is a fair-minded person;
- (b) is a person of ordinary intelligence, experience and education;
- (c) is neither perverse, nor morbid nor suspicious of mind;
- (d) is not avid for scandal;
- (e) does not live in an ivory tower, but can and does read between the lines in the light of that person’s general knowledge and experience of worldly affairs;
- (f) while prone to engage in a certain amount of loose thinking, reads a book with

more care and attention than he or she would a newspaper;

(g) reads the entire matter complained of and considers the context as a whole;  
and

(h) subscribes to general community standards.

593 The respondents noted that a publisher will not be liable for imputations that are only conveyed  
by a process of reasoning which involves the drawing of inferences on inferences; that is, for  
further inferences which some readers might draw from the inferences which ordinary  
reasonable readers would draw, by applying their own biases or prejudices, or indulging in an  
impermissible degree of speculation or loose thinking: *Mirror Newspapers Ltd v Harrison*  
[1982] HCA 50; (1982) 149 CLR 293, 300–1; *Lewis v Daily Telegraph Ltd* [1964] AC 234  
(HL), 274, 285-286.

## 8.2 Discussion

594 One matter that should be noted here is that the imputations all refer to Dr Gill as a psychiatrist  
when, in fact, he was a general practitioner. I do not consider that the Chapter, with its one  
reference to Dr Gill as a “fellow Chelmsford doctor” (pp 178-179), conveys any imputation  
that Dr Gill was a psychiatrist. In this sense, none of the alleged imputations about Dr Gill are  
conveyed as the Chapter does not convey that he was a psychiatrist. If I am incorrect in this  
regard then the comments below apply to Dr Gill.

595 The respondents accepted that the Chapter conveys imputations A to D and I with respect to  
Mr Herron, that is:

A The applicant’s gross negligence as a psychiatrist nearly killed his patient  
Barry Hart

B The applicant, a psychiatrist, falsely imprisoned his patient Barry Hart

C The applicant, a psychiatrist, caused his patient Barry Hart to deteriorate, in  
ten days, from a fit 37-year old man in peak physical condition to a person in  
agony and distress, vomiting blood and unable to move his limbs

D The applicant, a psychiatrist, caused his patient Barry Hart to be sedated and  
given electric shock treatment on six occasions, without Mr Hart’s consent

I The applicant’s gross negligence as a psychiatrist caused his patient Barry Hart  
to suffer brain damage and post traumatic stress

596 Imputation E (with respect to Mr Herron and Dr Gill) is that the applicant, a psychiatrist, used  
DST on his patients despite trials by other doctors deeming the practice too dangerous.

597 The applicants relied on pp 178-179 in which the Book states:

Other psychiatrists had rejected Bailey's theories. A trial of deep sleep therapy at Parramatta Psychiatric Hospital had been discontinued in 1957 after it was deemed too dangerous and unproductive. In 1959, the American Handbook of Psychiatry warned that the mortality rate for 'continuous of prolonged sleep treatment' was on average 1 to 3 per cent...

These advance warnings from significant figures in the medical profession did not deter Bailey and his fellow Chelmsford doctors, John Herron, John Gill and Ian Gardiner. Nor did the death toll mounting before their eyes.

598 The respondents accepted that the ordinary reasonable reader would understand that other psychiatrists had rejected DST and would understand that there had been one clinical trial which had concluded the practice was too dangerous and unproductive. The respondents submitted, however, that nothing refers to a larger number of trials coming to that conclusion. The ordinary reasonable reader would not have drawn conclusions about multiple trials having been carried out. As such, imputation E is not conveyed.

599 I agree with the respondents. The ordinary reasonable reader would not have conveyed to them the imputation of trials by other doctors deeming the practice too dangerous. They would understand that what was being conveyed was that one trial had been conducted with that result (as specifically identified) and that other psychiatrists had rejected DST (which is not the pleaded imputation).

600 Accordingly, imputation E is not conveyed with respect to Mr Herron or Dr Gill.

601 The respondents accepted that the Chapter conveys imputation F with respect to Mr Herron and Dr Gill: that the applicant, a psychiatrist, continued to use DST on his patients despite the number of deaths it caused.

602 Imputation G with respect to Mr Herron and Dr Gill is that the applicant, a psychiatrist, falsified death certificates. The applicants relied on the following references:

P 178-179: Bailey and his fellow Chelmsford doctors, John Herron, John Gill and Ian Gardiner.

P 179: Chelmsford Hospital operated like a secretive cult. The doctors and psychiatrists were operating in an era and environment where their authority was rarely questioned. Death certificates were falsified.

603 The respondents pointed to p 192 and the statement there that:

The commission [the Royal Commission] found that Bailey falsified as many as 17 death certificates.

604 The respondents observed that the ordinary reasonable reader would read the whole of the matter complained of, with the critical and cautious attention a book deserves. They would read

the first general reference (with the falsification of death certificates not attributed to anybody) as an event which would be described in greater detail later, as is the case (with reference to the Royal Commission’s finding that Dr Bailey falsified 17 death certificates). The ordinary reasonable reader, having noted in the early part of the Chapter the general proposition that “death certificates were falsified”, would come to conclude that this was done by Dr Bailey by reason of the specific reference later in the Chapter.

605 I agree with the respondents. There is no attribution of responsibility for the falsification on p 179. The ordinary reasonable reader would not assume that each of the doctors mentioned earlier falsified death certificates. They would read the reference proleptically, anticipating further information which they would find on p 192.

606 Accordingly, imputation G is not conveyed with respect to Mr Herron or Dr Gill.

607 Imputation H with respect to Mr Herron and Dr Gill is that the applicant, a psychiatrist, lied to his patients about how ill the patients were and denied those families visitation.

608 The applicants relied on:

P 178: Bailey and his fellow Chelmsford doctors, John Herron, John Gill and Ian Gardiner.

P 179: Chelmsford Hospital operated like a secretive cult. The doctors and psychiatrists were operating in an era and environment where their authority was rarely questioned ... Family members were regularly denied visitation rights and routinely lied to about how seriously ill their loved ones were.

609 The respondents submitted that:

Page 179 does not name either Mr Herron or Dr Gill as doctors who were responsible for family members being denied visitation rights and lied to about patients’ conditions. There is no identification in that paragraph of the reasons that this occurred. The focus of the whole chapter, read in context, is Dr Bailey. If the ordinary reasonable reader was to attribute responsibility for this matter to any doctor, it would be to Dr Bailey and not to Mr Herron or Dr Gill. For that reason, the imputation is not conveyed.

610 When the references on pp 178-179 are read in the context of the Chapter as a whole I agree with the respondents’ submissions. Dr Bailey is mentioned on p 177 as responsible for introducing DST to Chelmsford. The whole of p 178 concerns Dr Bailey. Mr Herron and Dr Gill are mentioned as Dr Bailey’s fellow Chelmsford doctors who were not deterred by the fact that other psychiatrists had rejected Dr Bailey’s theories nor by the mounting death toll. Read in that context the ordinary reasonable reader would not understand that Mr Herron and Dr Gill denied families visitation rights and routinely lied to them about how ill their loved ones were.

They would understand that Dr Bailey, the architect of DST, ensured that families could not visits and were not to be told how their loved ones were if they were ill under DST. This is reinforced by the reference on p 178 to the range of complications from “Bailey’s treatment”.

611 Accordingly, imputation H is not conveyed with respect to Mr Herron or Dr Gill.

612 Imputation J with respect to Mr Herron and Dr Gill is that the applicant’s gross negligence as a psychiatrist caused the death of many of his patients.

613 The applicants relied on the statements at p 180:

The Herald had been planning to run a series on the abuse of mental health patients, but the sacking of the Whitlam government that afternoon buried Hart’s story and the series. Herron and his colleagues at Chelmsford had dodged another bullet. A Herald series would surely have brought out more victims of Chelmsford and put pressure on the government to act. It may even have prevented more deaths.

Rosa Nicholson became the central figure in exposing the truth about the dozens of deaths caused by medical malpractice inside Chelmsford Hospital.

614 The respondents submitted that:

The matter complained of does not go close to conveying that Mr Herron or Dr Gill’s negligence caused the death of many patients. The imputation could only be made out if the chapter identified a significant proportion of the 24 patients mentioned on page 192 as having been the responsibility of Mr Herron or Dr Gill. It does not. The only patient of Mr Herron referred to in the chapter is Barry Hart, who did not die as a result of DST. As mentioned above (in respect of the previous imputation), the focus of the chapter was Dr Bailey and it is Dr Bailey’s responsibility for ‘many’ deaths that would be inferred by the ordinary reasonable reader, not Dr Gill or Mr Herron.

In addition, the matter complained of refers to the treatment that was carried out and the number of deaths which occurred. It does not state that either that [sic] any doctors’ negligence caused the deaths or, even, that DST caused the deaths.

615 I agree with the respondents’ submissions. There is no imputation conveyed by the matter complained of that the negligence of Mr Herron and Dr Gill caused the death of many of their patients. The ordinary reasonable reader would know that Mr Herron’s patient, Mr Hart, had survived his treatment at Chelmsford. There is no reference to any patient of Dr Gill, let alone one having died. Dr Bailey had also been identified as the person experimenting with DST at Chelmsford (p 178).

616 Accordingly, imputation J is not conveyed with respect to Mr Herron or Dr Gill.

617 Imputation K with respect to Mr Herron and Dr Gill is that the applicant, a psychiatrist, engaged in sustained medical malpractice and abuse of his patients.



618 The applicants relied on:

P 180: The Herald had been planning to run a series on the abuse of mental health patients, but the sacking of the Whitlam government that afternoon buried Hart's story and the series. Herron and his colleagues at Chelmsford had dodged another bullet. A Herald series would surely have brought out more victims of Chelmsford and put pressure on the government to act. It may even have prevented more deaths.

P 180: Rosa Nicholson became the central figure in exposing the truth about the dozens of deaths caused by medical malpractice inside Chelmsford Hospital.

P 181: When she returned as an undercover agent, she copied and removed medical records that became key pieces of evidence exposing a horror show of sustained medical malpractice and abuse.

619 The respondents noted that the applicants also relied on text at pp 184, 192, 196, 198 and 201 although these references are not identified in the applicants' final submissions (Schedule 2). On the basis that the respondents are correct, I note the respondents submissions as follows:

What was done to Mr Hart is detailed in the chapter, Mr Hart is identified as a patient of Mr Herron and his conduct in administering DST led to Mr Hart successfully taking civil proceedings against him for false imprisonment and assault and battery. However, the pleaded imputation is much wider and refers to 'sustained' medical malpractice and abuse. That would require some suggestion that Mr Herron engaged in similar conduct for more than one patient over a lengthy period of time.

The primary focus for this imputation is page 184 which contains reference to files retrieved by Rosa Nicholson comprising a 'catalogue of psychiatric abuse and malpractice'. That description is contained in a paragraph which commences with 'But Bailey was the one who was about to feel rattled'. It follows from a paragraph which sets out in detail various aspects of Dr Bailey's conduct at Chelmsford Private Hospital. The ordinary reasonable reader is thereby directed to Dr Bailey's conduct, rather than any suggestion that the 'catalogue' related to Mr Herron or Dr Gill.

620 I agree with the respondents' submissions. The only patient of Mr Herron's who is mentioned is Mr Hart and full details are given of his treatment and its consequences. There is no other reference to any patient being one of Mr Herron's (although there is a reference to Peter Clarke dying less than half an hour after being given ECT by Mr Herron). No patient of Dr Gill's is mentioned. In contrast, the focus of the Chapter is on Dr Bailey as experimenting with DST at Chelmsford, as using DST, as DST being Dr Bailey's theory, that Dr Bailey ignored Dr Sargent's safeguards for narcosis, that Dr Bailey was dismissive and abusive of nurses during emergencies, that Dr Bailey would be rattled by the files showing a catalogue of psychiatric abuse and malpractice, and that Dr Bailey was feeling the heat.

621 Accordingly, imputation K is not conveyed with respect to Mr Herron or Dr Gill.

622 Imputation L with respect to Mr Herron and Dr Gill is that the applicant, a psychiatrist, defrauded his patients' health funds.

623 The applicants relied on:

P 184: Rosa... salvaged a number of ECT books from the rubbish bin, which showed doctors defrauding the patient's health funds.

624 The respondents submitted:

This imputation is said to arise from the reference on page 184 to 'doctors defrauding the patient's health funds'. The reference must be read in context. It appears in a passage devoted to describing the documents obtained by Rosa Nicholson. Later on the page, the author refers to Dr Bailey 'making hundreds and thousands of dollars out of his patients' and to Dr Bailey being the 'one who was about to feel rattled'. In light of those matters, the ordinary reasonable reader would conclude that the reference to defrauding of health funds was a reference to Dr Bailey. Neither applicant is mentioned in this context.

625 While I accept that the reference on p 184 is to "doctors", I agree with the respondents that read in context of the page as a whole the ordinary reasonable reader would understand that the reference to doctors defrauding health funds was a reference to Dr Bailey.

626 Accordingly, imputation L is not conveyed with respect to Mr Herron or Dr Gill.

627 Imputation M with respect to Mr Herron and Dr Gill is that the applicant, a psychiatrist, traumatised many of his patients by giving them deep sleep therapy without their consent.

628 The applicants relied on:

P 184: The patients who survived deep sleep therapy woke up heavily traumatised ... Many were given deep sleep therapy without their consent.

629 The respondents submitted that such an imputation:

...can be envisaged in relation only to Mr Herron (not Dr Gill) and only relating to the treatment of Mr Hart (not any other patients). The pleaded imputation is far wider. Read in context, the reference on page 184 to patients being treated without their consent would be read by the ordinary reasonable reader as a description of Dr Bailey's treatments. The same can be said for page 192. The reference to patients being treated without consent is contained in the same sentence as the reference to Dr Bailey falsifying death certificates. The imputation is not conveyed by the matter complained of.

630 I agree with the respondents. In the context of the Chapter as a whole it is not open to infer that the ordinary reasonable reader would understand that Mr Herron or Dr Gill traumatised many of their patients by giving them deep sleep therapy without their consent. Apart from Mr Herron's treatment of Mr Hart, there is no reference to Mr Herron or Dr Gill administering DST. There are numerous references to DST being Dr Bailey's treatment.

631 Accordingly, imputation M is not conveyed with respect to Mr Herron or Dr Gill.

632 The respondents accepted that the Chapter conveys imputation N with respect to Mr Herron.

## 9. JUSTIFICATION

633 Section 25 of the Act provides that:

It is a defence to the publication of defamatory matter if the defendant proves that the defamatory imputations carried by the matter of which the plaintiff complains are substantially true.

634 The applicants submitted that:

If the Court were satisfied that some, but not all, of the imputations were substantially true, the principle that the defence of justification operates on an ‘all or nothing basis’ means that the Court would be bound to dismiss the justification defence in relation to all of the imputations, including those which the Court otherwise thought were substantially true: see *Fairfax Digital Australia & New Zealand Pty Ltd v Kazal* (2018) 97 NSWLR 547 at [38] per Meagher JA, [96] per Gleeson JA.

635 In *Fairfax Digital Australia & New Zealand Pty Ltd v Kazal* [2018] NSWCA 77; (2018) 97 NSWLR 547 at [38] Meagher JA referred to:

...a proposition assumed or decided in intermediate appellate courts, namely, that each of the defences under ss 25 and 26 operates on an all-or-nothing basis.

636 Gleeson JA at [96] said:

It is well-established that the defence of justification under s 25 and at common law operates on an all or nothing basis, that is, all the defamatory imputations must be proved to be true.

637 The respondents referred to *Fairfax Media Publications Pty Ltd v Kermode* [2011] NSWCA 174; (2011) 81 NSWLR 157 at [86] that:

In summary, a defendant seeking to justify the defamatory matter under the 2005 Act may take the following courses of action, some statutory, some based on the common law:

(a) prove that the defamatory imputations carried by the defamatory matter of which the plaintiff complains are substantially true: s 25;

...

(c) to the extent that the defendant fails to establish all the defamatory imputations carried by the defamatory matter of which the plaintiff complains are substantially true, rely on those proved to be true in mitigation of the plaintiff’s damages: partial justification;

...

638 The respondents also referred to *TCN Channel Nine Pty Ltd v Pahuja* [2019] NSWCA 166 where Basten JA in obiter dicta noted at [73]:

Section 25 requires the defendant to prove that specific imputations are substantially true; it does not say that the defence arises only if the defendant proves that all the defamatory imputations are substantially true. It is not inconsistent with the language of s 25 that a defamatory imputation which is substantially true should be disregarded in considering the harm done to the reputation of the plaintiff.

639 His Honour also said at [78] that:

Even on the respondent's case, a successful plea of justification to fewer than the whole of the imputations relied on by the plaintiffs may affect the assessment of damages.

640 The respondents observed that:

In any case, the resolution of that issue may make little difference. If some imputations are proved true and some not, this will affect the Court's assessment of the Applicants' reputations, in any event.

641 Finally, as to the fact that Dr Gill was a general practitioner and not a psychiatrist the key material fact is that he was a medical practitioner at the time of his involvement with Chelmsford. When it comes to the issue whether the imputations are substantially true the distinction between Dr Gill being a psychiatrist and a general practitioner is immaterial. That is to say, the mere fact that Dr Gill was a general practitioner and not a psychiatrist does not mean that any imputation is not *substantially* true because the material fact of him being a medical practitioner at the relevant time is true.

## **9.1 Imputation A**

642 Imputation A: The applicant's (Mr Herron's) gross negligence as a psychiatrist nearly killed his patient Barry Hart.

643 As noted above, imputation A is conveyed.

644 I accept the respondents' submissions that:

- (1) the term "gross negligence" does not appear in the Book;
- (2) the ordinary reasonable reader may or may not understand the term "gross negligence" to have legal significance of some kind (a bit like "equity"), but he or she certainly does not know what constitutes gross negligence in law, or the elements of manslaughter; and
- (3) to the ordinary reasonable reader "gross negligence" is an ordinary English phrase which means no more or less than "serious negligence".

645 The applicants contended that:

- (1) the respondents have been unable to demonstrate that Mr Herron was negligent as a psychiatrist;
- (2) DST was an accepted practice in 1973. Mr Herron explained the treatment to Mr Hart and Mr Hart attended Chelmsford. Mr Hart willingly got into bed and subjected himself to the treatment;
- (3) Mr Herron's response to each of the side-effects of DST experienced by Mr Hart were reasonable in the circumstances;
- (4) the truth of this imputation turns on the evidence of Mr Hart, who has not been subjected to cross-examination in these proceedings but who was seriously discredited at the Royal Commission; and
- (5) the truth of this imputation also turns on the expert opinion of Dr Smith, who cannot now identify any factual assumption he made about Mr Hart, other than the content of the medical records and who was a biased witness whose evidence should not be accepted.

646 For the reasons given above I reject each of these contentions. The weight of the evidence is overwhelmingly to the contrary. By administering DST to Mr Hart in 1973 Mr Herron's conduct fell so far below the standard of care of a reasonable psychiatrist that the infliction of the treatment on Mr Hart must be found to constitute gross negligence. The evidence is also clear that the treatment nearly killed Mr Hart. The evidence of Dr Smith and Dr Phillips also exposes the grossly negligent treatment Mr Hart was subjected to while at Chelmsford. Following the treatment Mr Hart's condition was so serious he had to be transferred to Hornsby Hospital where he was treated for two weeks. The evidence is that he was diagnosed with bilateral bronchopneumonia and a pulmonary embolus (well-known serious complications of narcosis treatment, let alone of DST as administered at Chelmsford). Dr Smith estimated Mr Hart's chances of survival on transfer at 50%. The evidence is more than sufficient to substantiate the truth of imputation A.

## 9.2 Imputation B

647 Imputation B: The applicant (Mr Herron), a psychiatrist, falsely imprisoned his patient Barry Hart.

648 As noted above, imputation B is conveyed.

649 The applicants contended that:

There was no false imprisonment of Barry Hart. He was plainly an opportunistic liar who wish to blame others for any setback that he experienced in life. Barry Hart attended [Chelmsford] voluntarily, with his overnight items for the purpose of a lengthy stay. He knew about the treatment he was prescribed and consented to it, including by getting into bed after speaking to Brian Dilworth.

Hart's story about the magic white pill was a complete fabrication, as is evident from the [Chelmsford] records – there was no such pill and he was awake from time to time throughout the treatment.

650 I reject these submissions. Mr Hart's consistent evidence that he did not consent to DST and ECT should be accepted for the reasons given above. Even if Mr Hart's reference to having been given a pill which made him unconscious is incorrect, that does not undermine the credibility of the essence of his complaint, that he was subjected to DST and ECT without his consent. There is evidence of patients being given Valium or other pills on arrival to calm them down before being rendered unconscious by an injection of sodium amytal. Mr Hart's version of events about being given a white pill is by no means implausible on the whole of the evidence (noting the evidence confirms that he was given two tablets of Mylodorm, a barbiturate, before DST commenced). In any event, it is clear Mr Hart was rendered unconscious and maintained in a drugged and stuporous state without his consent which made him effectively a prisoner at Chelmsford for the duration of his DST. The fact that he may have had brief periods of consciousness during his DST does not mean that he was consenting to the continued administration of drugs, nor that he was other than being confined against his will.

651 Accordingly, imputation B is substantially true.

### **9.3 Imputation C**

652 Imputation C: The applicant (Mr Herron), a psychiatrist, caused his patient Barry Hart to deteriorate, in ten days, from a fit 37 year old man in peak physical condition to a person in agony and distress, vomiting blood and unable to move his limbs.

653 As noted above, imputation C is conveyed.

654 The applicants contended that:

- (1) there is no evidence that Mr Hart was in peak physical condition before Chelmsford;
- (2) he was not in agony and distress because of DST but was wandering around and speaking to people and could move his limbs; ad
- (3) nothing Mr Herron did or omitted to do caused any of these symptoms in Mr Hart.

655 I disagree. The applicants' view of the evidence is selective and distorted. Mr Hart's evidence about his peak physical condition was persuasive. It is supported by the nurses' observations of his condition on admission. When he came around from DST he was in agony and unable to move and felt paralysed. He suffered severe chest pain. He vomited blood. It is obvious that Mr Herron's subjecting of Mr Hart to DST and ECT had caused him to deteriorate from a fit 37 year old man in peak physical condition to a person in agony and distress, vomiting blood and unable to move his limbs.

656 Accordingly, imputation C is substantially true.

#### **9.4 Imputation D**

657 Imputation D: The applicant (Mr Herron), a psychiatrist, caused his patient Barry Hart to be sedated and given electric shock treatment on six occasions, without Mr Hart's consent.

658 As noted above, imputation D is conveyed.

659 The applicants contended that Mr Hart attended Chelmsford voluntarily and admitted himself and no one in fact knows whether the ECT form was signed and in any event lack of written consent is not the issue.

660 For the reasons given above I consider the inferences that must be drawn from the evidence are clear. Mr Hart was never told what DST involved and did not consent to DST. He refused to consent to ECT. Mr Herron nevertheless caused Mr Hart to be sedated and given ECT on six occasions. As the respondents submitted:

- (1) Mr Hart's unwavering and direct recollections are to be preferred to Mr Dilworth's evidence of what his usual practice involved;
- (2) nothing in Mr Hart's evidence at the Royal Commission relating to events after Chelmsford casts any doubt about what happened to him at Chelmsford;
- (3) Mr Herron's evidence about informing Mr Hart he would be sedated and given ECT is self-serving and unpersuasive. It is also inherently unlikely that Mr Herron ever informed any patient about the details of DST and the risks involved in it, so no patient could have made a decision constituting informed consent;
- (4) the evidence of the missing part of the ECT form strongly suggests Mr Hart never in fact gave consent to ECT.

- (5) there is no evidence that Mr Hart in fact gave consent to receiving DST (and the evidence is strongly to the contrary); and
- (6) Mr Hart's experience, on the whole of the evidence, did not represent an isolated example of patients being subjected to DST and ECT without their consent. The fact that there was no written consent form for a treatment such as DST discloses the cavalier attitude taken by all the doctors involved in DST at Chelmsford to the fundamental issue of consent.

661 For these reasons, imputation D is substantially true.

### **9.5 Imputation I**

662 Imputation I: The applicant's (Mr Herron's) gross negligence as a psychiatrist caused his patient Barry Hart to suffer brain damage and post-traumatic stress.

663 As noted above, imputation I is conveyed.

664 The applicants contended that there is no evidence that Mr Hart suffered brain damage. According to the applicants Dr Smith's one line statement about this in his expert report can be given no weight as he was unable to identify any assumed fact upon which he based that opinion.

665 To the contrary, there is good reason to accept Dr Smith's evidence that Mr Hart suffered anoxic brain damage. Dr Smith interviewed Mr Hart in 1979 for four and a half hours and reached this conclusion. He was qualified to do so. As the respondents said, Dr Smith is the only expert who has assessed Mr Hart in person post-Chelmsford, and therefore his evidence should be accepted.

666 Mr Hart also gave evidence that he suffered post-traumatic stress as a result of his experiences at Chelmsford. His evidence should be accepted. It is consistent with the potentially traumatising nature of DST and the evidence of other patients about the impact their treatment at Chelmsford has had on their lives.

667 Accordingly, imputation I is substantially true.

### **9.6 Imputation N**

668 Imputation N: The applicant (Mr Herron), a psychiatrist, assaulted and battered his patient, Barry Hart.



669 As noted above, imputation N is conveyed.

670 The applicants submitted that as Mr Hart consented to DST and ECT there was no assault and battery.

671 Given my conclusions about Mr Hart not consenting to DST or ECT I have no difficulty in concluding that in subjecting Mr Hart to DST and ECT Mr Herron assaulted and battered his patient, Barry Hart.

672 As the respondents submitted:

- (1) battery and assault are separate torts;
- (2) battery is intentionally bringing about a harmful or offensive contact with another person's body: *Secretary, Department of Health and Community Services v JWB and SMB [Marion's Case]* [1992] HCA 15; (1992) 175 CLR 218;
- (3) assault is intentionally creating in another person an apprehension of imminent harmful or offensive conduct: *R v Knight* (1988) 35 A Crim R 314 at 316-317; and
- (4) however, the "traditional common law distinction between assault and battery has largely fallen away for the purpose of application of the modern law of assault": *McIntyre v R* [2009] NSWCCA 305; (2009) 198 A Crim R 549 at [40].

673 Having regard to these matters I accept the respondents' submission that:

...the ordinary reasonable reader would understand the term 'assault and battery' as being harmful or offensive contact with another person's body without that person's consent and without lawful excuse. That is, an ordinary reasonable reader would not understand the term to necessarily encompass the victim having an apprehension of the conduct prior to it being inflicted. In respect of 'harmful or offensive contact', authorities have held that it does not matter whether the person intended to harm, 'offensive' is any type of contact outside the accepted usages of daily life and it is not necessary that there be actual and immediate contact; contact can include an act by a person that causes something to happen to someone, for example a chair being pulled out from under a person causing them to fall to the floor.

674 Mr Herron, on the evidence, subjected Mr Hart to harmful or offensive contact without Mr Hart's consent and without lawful excuse. He caused him to be administered sedating drugs which kept Mr Hart effectively unconscious for 10 days. He administered ECT to Mr Hart on six occasions. In both cases, the contact with Mr Hart was harmful and offensive and done without his consent.

675 Accordingly, imputation N is substantially true.

## 9.7 Imputation E

676 Imputation E: The applicant (Mr Herron and Dr Gill), a psychiatrist, used deep sleep treatment on his patients, despite trials by other doctors deeming the practice too dangerous.

677 As noted above, imputation E is not conveyed.

678 The applicants contended that:

There were no trials deeming it too dangerous. All of the literature summarised in Schedule 1 and set out in Table 3 shows that it was a treatment that worked.

Dr Herron gave evidence that the Parramatta trial was conducted by Dr Bailey. He did not deem the practice too dangerous - he decided that the nursing staff at Parramatta were not competent enough to carry it out. The 3 lines from Dr Barclay at the RC that the applicants had no opportunity to cross-examine on is insufficient to prove this imputation.

679 I disagree. It does not matter that the applicants could not cross-examine Dr Barclay. He gave evidence to the Royal Commission that there was a small trial involving patients at Parramatta Psychiatric Centre in 1957 but:

We decided that we didn't think it was terribly effective and it scared the living daylight out of us. We thought it was too dangerous to go on with at least so far as we were concerned in that setting. I mean, we just didn't like it.

680 Mr Herron said the trial was carried out by Dr Bailey but was abandoned because he did not feel the nurses were competent to supervise the patients. Whatever Dr Bailey thought, Dr Barclay plainly considered the treatment too dangerous to proceed with the trial (let alone use the treatment in day-to-day practice) and the trial was abandoned. The trial involved a small number of patients and thus each patient must have had the treatment trialled upon them in a manner warranting the description of "trials". Further, if, as Dr Bailey thought, the nurses were not competent to supervise the patients it necessarily follows that the result of the trial was that the treatment with supervision by nurses was too dangerous to proceed as a trial. If it were otherwise Dr Bailey would have proceeded with the trial. What occurred between 1957 and Dr Bailey's commencement of DST at Chelmsford in the early 1960s under the supervision of nurses is not apparent but it may readily be inferred that the 1957 trial was abandoned because doctors (including Dr Bailey) considered it to be too dangerous to be carried out in the circumstances.

681 Despite this, both Mr Herron and Dr Gill subjected patients to DST.

682 Accordingly, if conveyed, imputation E is substantially true with respect to Mr Herron and Dr Gill.

### 9.8 Imputation F

683 Imputation F: The applicant (Mr Herron and Dr Gill), a psychiatrist, continued to use deep sleep treatment on his patients despite the number of deaths it caused.

684 As noted above, imputation F is conveyed.

685 The applicants contended that:

- (1) there is no evidence that DST caused a significant number of deaths; and
- (2) there is no pleading or proof that DST did not work. In fact the evidence was one-sided on that issue - the evidence from Dr Bailey, Mr Herron, the nurses and the literature all prove that DST did work.

686 I reject these contentions.

687 There is ample evidence that DST caused a significant number of deaths. The evidence is also clear that Mr Herron and Dr Gill knew that patients had died while undergoing DST at Chelmsford. Given that it was a small private hospital they could be expected to know of every death under DST from the time of their involvement with Chelmsford. Mr Herron said in his affidavit that he was “aware at the time that sedation patients had died”. Dr Gill was present after Ann Bennett died and was aware of the death of his own patient, John Adams, but in any event it would be inferred on the evidence that given his role at Chelmsford and involvement with the hospital he would have known of each of the deaths from 1972 onwards. Mr Herron and Dr Gill continued to use DST despite the number of deaths it caused. Mr Herron continued until 1979. Dr Gill gave another patient DST a few weeks after the death of John Adams.

688 The imputation does not relate to anything other than the deaths DST caused. It is not necessary for the respondents to prove that DST was ineffective. In any event, the evidence is not one sided on that issue. The evidence of Mr Herron and Dr Gill (and Dr Bailey) about DST working must be rejected outright as self-serving. The evidence of the nurses is by no means supportive of the efficacy of the treatment and to the extent there is such evidence it is anecdotal and observational rather than evidence-based. None of this evidence is reliable. The reliable evidence is that of the respondents’ experts and the patients. The evidence of the experts is that DST was not indicated for any psychiatric condition and was an experimental and unproven

treatment for which there was no justification – that is, no possible benefit could justify the risk of death and serious harm involved. The evidence of the patients and their relatives is firmly to the effect that DST caused significant harm without any benefit. The literature relied upon by the applicants does not concern DST at all and provides no scientifically credible assessment of its benefits (in particular, the literature does not move beyond an anecdotal recording of allegedly successful treatment which is manifestly of no scientific value). Faced with this, the submission that the evidence is one-sided to the effect that DST did work is nonsensical.

689 Accordingly, imputation F is substantially true with respect to Mr Herron and Dr Gill.

## **9.9 Imputation G**

690 Imputation G: The applicant (Mr Herron and Dr Gill), a psychiatrist, falsified death certificates.

691 As noted above, imputation G is not conveyed.

692 The applicants contended that there was no evidence to support the pleaded allegation that Mr Herron falsified the death certificate of Ms Francis. According to the applicants he clearly formed the view that she died of a myocardial infarction. There is no evidence that he wrote something he knew to be false on the death certificate. The applicants said that the evidence showed that:

- (a) Dr Herron had not completed many death certificates in the past;
- (b) He followed the instructions for completing the death certificate that he had;
- (c) The instructions read to the effect: A medical practitioner shall not sign a certificate if in their opinion the patient has died while under, or as a result of the administration of, an anaesthetic administered in the course of a medical, surgical or dental operation or procedure, or an operation or procedure of a like nature;
- (d) There was nothing in those instructions about mandatory reporting to the coroner by the mere fact of the use of an anaesthetic within 24 hours of death;
- (e) He either did not recall at the time of completing the certificate that she had the anaesthetic less than 24 hours before her death or otherwise formed the view that it did not contribute to her death.

693 Further, they said:

The death certificate he completed may never have been submitted, because he ultimately wrote to the coroner as evidenced in Ex 49 (3) p2-3. The coroner issued a death certificate a few days after her death on 30 March 1976, citing the cause of death as ‘Pulmonary oedema, Heart failure, (History) Chronic alcoholism’: MED00091.

694 The applicants contended that the pleaded allegation that Dr Gill knew or should have known the contents of Ms Bennett's death certificate and that it was false had not been proved. Further, the unpleaded allegation put to Dr Gill in cross-examination that he agreed to falsify Ms Podio's death certificate cannot be substantiated.

695 The respondents identified the relevant statutory context as follows:

In 1960, section 46 of the *Coroners Act 1960* (NSW) (Ex. 49, Tab 12) inserted section 27A of the *Registration of Births, Deaths and Marriages Act 1899* (NSW) (Ex. 49, Tab 13) so that a medical practitioner was prohibited from signing a death certificate if the person:

Has died while under, or as a result of the administration to him of, an anaesthetic administered in the course of a medical, surgical or dental operation or procedure, or an operation or procedure of a like nature.

In 1963, section 3 of the *Coroners Amendment Act 1963* (NSW) amended the 1899 Act so that the section read as follows (emphasis added):

Has died while under, or as a result of **or within a period of twenty-four hours after** the administration to him of, an anaesthetic administered in the course of a medical, surgical or dental operation or procedure, or an operation or procedure of a like nature.

That requirement remained, when the 1899 Act was replaced by the *Registration of Births, Deaths and Marriages Act 1973* (NSW). It appears in section 24(7) of that Act. That is the section which applied at the time of Ms Francis' death.

696 The respondents noted that the evidence establishes that on 14 March 1976 Mr Herron completed the death certificate for Ms Francis (Herron XXN at T2627.22-23). He stated on the certificate that Ms Francis had died of myocardial infarct: Herron XXN at T401.24-28. He did not mention that she had been receiving DST when she died: Herron XXN at T401.30-31.

697 Mr Herron completed the death certificate despite the fact that Ms Francis died within 24 hours of being administered an anaesthetic. As such, it was an offence for Mr Herron to sign the death certificate: s 57(4) of the *Registration of Births, Deaths and Marriages Act 1973* (NSW).

698 Mr Herron gave this evidence in the *Hart v Herron* proceedings:

Q. When you signed the death certificate you were aware that the result of signing it in that form would be that there would have been no inquest unless somebody wanted it? A. I am aware, and I would have been then, that if a death certificate is signed there will not be an inquest unless something else is brought up.

Q. The result in what you were doing was that there would be no inquest unless something else occurred? A. Yes.

Q. You were quite conscious of that when you did it? A. I am conscious of the fact that on signing a death certificate there is no inquest.

Q. You had not forgotten that the anaesthetic had been administered? A. I certainly had forgotten that.

...

Q. When you signed the death certificate on 14 March I put it to you that you could not have forgotten that you had given this lady anaesthetic the previous morning? A. I certainly had.

Q. One of the things he had to apply his mind to is whether there has been an anaesthetic given within 24 hours? A. Yes, that is one of the things.

Q. Did you apply your mind to that? A. I did not apply my mind to it adequately.

Q. Obviously. Did you apply it at all? A. When I was writing the death certificate I was thinking whether there was a reasonable explanation of this person's death. I did not run through the checklist of the Coroner's Act specifically at that time.

699 Mr Herron gave this evidence in the Royal Commission about using the material that was on the back of the death certificate form:

Q. What did you read that morning? A. I believe I read the top of those two sets of instructions

Q. You read that you were not to sign the certificate if in your opinion the patient had died while under or as a result of the administration of an anaesthetic administered in the course of a medical, surgical or dental operation or a procedure or an operation or procedure of a like nature, among other things? A. Yes.

Q. What did you think of when you read it? A. I did not think Mrs Francis died as a result of an anaesthetic.

Q. What about the injection which you had given her the previous morning, what consideration did you give to that? A. I did not see that it was a factor concerned with her death.

Q. You turned your mind to the fact that you had administered this drug to her, I take it? A. I would have to assume I would have.

700 The respondents submitted that the two versions are irreconcilable. In the first, he forgot about the anaesthetic and did not use the checklist provided on the back of the death certificate. In the second, he used the checklist which led him into error, but had applied his mind to the fact that Ms Francis had been given anaesthetic. After the inconsistency was pointed out to him in the Royal Commission he could not say which version was correct: Ex. 48, Tab 16, p 1516. He was aware of the requirements of the legislation, but could offer no coherent explanation of why he failed to notify the Coroner of the circumstances of Ms Francis' death: Ex. 48, Tab 16, p 1517.

701 The respondents noted that:

When asked during cross-examination in these proceedings about this inconsistency, Mr Herron was quick to blame any inconsistencies on external matters, including:

- (a) possible errors in the Royal Commission transcript (Herron XXN at T 2473.12-13);
- (b) issues with the question asked by senior counsel for Mr Hart during the *Hart v Herron* Trial: Herron XXN at T2471.12-17; and
- (c) the fact that he may have been confused when answering questions in *Hart v Herron*: Herron XXN at T2467.40-46.

In respect of the signing of the death certificate, Mr Herron's answers in these proceedings were varied, but included the following:

- (a) that he could not remember the incident: Herron XXN at T2471.19-27;
- (b) that despite that, he denies knowing that he was required not to sign the death certificate: Herron XXN at T2462.5-10; T2479.28-30;
- (c) that he read the back of the death certificate form and interpreted it as he thought he should after discussing it with and getting advice from others: Herron XXN at T2629.43-14, T2632.19-29;
- (d) that he had forgotten when signing the death certificate that he'd given her an anaesthetic in the previous 24 hours: Herron XXN at T2627.45-2628.10;
- (e) that he knew when signing the death certificate that he had administered an anaesthetic the previous morning: Herron XXN at T2632.1-6;
- (f) that he did not know that by signing the death certificate it was less likely there would be an inquest into her death: Herron XXN at T2467.31-35, T2473.22-28.

702 The respondents submitted that Mr Herron's evidence was plainly unreliable. To the contrary of his evidence, the following inferences should be drawn from the evidence as a whole:

The Court should not accept that Mr Herron forgot that he had administered anaesthetic to Ms Francis within 24 hours of her death. No doubt, in order to form a view about Ms Francis' cause of death, Mr Herron must have considered the type of treatment she was receiving, when he had last seen her and what condition she was in at that time. That previous time was when he saw her on 13 March 1976 for the purpose of giving her an ECT at which time he administered an anaesthetic: MED00089.14 (RTB7). That treatment was recorded in the Chelmsford notes, which Mr Herron wrote in, on the same day he completed the death certificate: MED00089.15 (RTB7).

Whether or not he read the form that was on the back of the death certificate, Mr Herron knew he was legally required not to prepare that certificate. Mr Herron agreed to that proposition at the Royal Commission, and, more importantly, it follows from Mr Herron's senior role at Ryde Hospital and his responsibilities there: Ex. 48, Tab 16, pg. 1517.

The Court can therefore conclude that Mr Herron signed the death certificate for Ms Francis, despite knowing that this was unlawful.

One then needs to consider why he would do that. The obvious answer is that he did so to avoid a coronial inquiry into Ms Francis' death so as to avoid scrutiny of the experimental drug regime which caused Ms Francis' death. That this was his purpose can also be inferred from the entirely inconsistent evidence he has given on the topic in *Hart v Herron*, the Royal Commission and these proceedings.

703 I accept these submissions which involve obvious inferences from the objective circumstances. Mr Herron's self-serving and inconsistent evidence over the years leads to the conclusion that he signed the death certificate to avoid a coronial inquiry into Ms Francis' death when, on the evidence, the actual cause of death was DST. In any event, the evidence of Dr Kariks, a pathologist, is clear – there was no evidence of a myocardial infarction in Ms Francis' death. Mr Herron's stated cause of death was false. In all of the circumstances it must be inferred that Mr Herron identified myocardial infarction as the cause of Ms Francis's death rather than DST deliberately because he wished to avoid any scrutiny of DST as the cause of her death. As such, the evidence establishes that Mr Herron falsified the death certificate of Ms Francis.

704 As the respondents further noted, Ann Bennett was admitted to Chelmsford under the care of Dr Bailey on 27 October 1975 and commenced sedation that evening: MED00002.1, 15 (RTB4). Despite not signing a consent form, she was administered ECT by Mr Herron on 29 October 1975: MED00002.17 (RTB4). She died at Chelmsford while under DST at 5.15am on 31 October 1975: MED00002.18 (RTB4). Dr Bailey signed the death certificate which states:

- (a) the direct cause of death was a coronary occlusion;
- (b) the antecedent cause of death was excess obesity;
- (c) chronic lumbar spine disease and excess obesity contributed to the death; and
- (d) Dr Bailey had last seen Ms Bennett on 30 October 1975.

705 Dr Joseph examined the relevant documents and concluded that the stated cause of death was probably incorrect and the most probable cause of death was that she had drowned in her own secretions and that DST was the primary cause of death. There is no reason not to accept Dr Joseph's opinions in preference to those of Dr Bailey who had a strong motive not to wish to see another inquest into a DST caused death. It must be inferred that Dr Bailey falsified the death certificate to avoid identifying DST as the cause of death. There is also no evidence that Dr Bailey saw Ms Bennett on 30 October 1975 and I conclude that part of the certificate is also false.

706 Dr Bailey was with Dr Gill at the time he signed the death certificate. The nurse's notes for Ms Bennett record that both Dr Bailey and Dr Gill attended Ms Bennett shortly after her death: MED00002.18 (RTB4). The cause of death from the death certificate is recorded next to their names in the notes. As the respondents put it:

Dr Gill agreed in cross examination that the notes record him and Dr Bailey attending together, and that the death of any patient at Chelmsford was a matter of concern for



him: Gill XXN at T304-5. However, despite stating that he had no recollection of Ms Bennett's death, Dr Gill refused to accept that as an attending doctor he would have discussed with Dr Bailey, or even considered, her possible cause of death: Gill XXN at T304-5. That evidence should not be accepted. The Respondents submit that it is clear that Dr Gill must have known the cause of death listed by Dr Bailey and that it was false.

707 I accept the respondents' submissions. It is inconceivable that Dr Bailey and Dr Gill did not discuss and agree upon the stated cause of death of Ms Bennett. They both had good reason to wish to avoid implicating DST in her death. The objective evidence combined with their strong motive establishes the inference that they agreed to identify her cause of death as coronary occlusion despite there being no evidence to support that conclusion. In other words, Dr Bailey and Dr Gill were involved in the falsification of Ms Bennett's death certificate.

708 Ms Podio died at Chelmsford on 12 August 1977 at approximately 6.30am: MED00059.25-26 (RTB6), MED00058.35 (RTB6). Dr Bailey signed her death certificate. It states that:

- (a) the direct cause of Ms Podio's death was a pulmonary embolus;
- (b) the antecedent causes of Ms Podio's death were severe depression and schizophrenia; and
- (c) Dr Bailey had last seen Ms Podio alive on 11 August 1977.

709 Dr Smith's opinion was that the likely cause of Ms Podio's death was abdominal obstruction caused by DST. I accept Dr Smith's evidence. Consistent with the inferences drawn above, I infer that Dr Bailey had good reason not to identify DST as the cause of her death and thus falsified her death certificate. There is also no record of Dr Bailey having seen Ms Podio on 11 August 1977 and the certificate's statement to this effect is false. Further, as the respondents noted:

Mr Herron gave Ms Podio ECT on 11 August 1977 with anaesthetic: MED00056.7-8 (RTB6); MED00058.6 (RTB6). Considering the evidence that at this time Mr Herron ordinarily attended to give ECTs at approximately 8am, it can be inferred that the ECT and anaesthetic were delivered after 6.30am on the 11th of August. As discussed above in relation to Ms Francis, at that time a death certificate could not be signed by a doctor in circumstances where an anaesthetic had been delivered in the previous 24 hours. Accordingly, Ms Podio's death certificate was false in that it should never have been signed in these circumstances, which in effect denied that an anaesthetic had been delivered to her in the previous 24 hours.

710 Dr Gill had attended Ms Podio the day before her death and directed she be given Epsom salts. The respondents submitted:

At the time of Ms Podio's death Dr Gill was the administrator of the hospital, he attended frequently, he was treating his own patients with DST, the death of any patient at Chelmsford was a concern to him (Gill XXN at T303.1-2) and as recently as 12

hours before he had treated Ms Podio on Dr Bailey's behalf when she was seriously ill. Despite his denials (Gill XXN at T258.1-24), the Court should infer that Dr Gill agreed with Dr Bailey that 'pulmonary embolus' would be listed as the cause of death despite knowing that the likely or probable cause of her death was an abdominal obstruction.

711 I found Dr Gill's evidence about his involvement unconvincing. Given her symptoms it must have occurred to Dr Gill that the cause of Ms Podio's death was abdominal obstruction, but he refused to countenance this obvious likelihood. Despite this, there is insufficient evidence to infer an agreement with Dr Bailey that the cause of her death be falsely listed as pulmonary embolus. In contrast to Ms Bennett, there is no evidence that Dr Gill was present at the signing of the death certificate. There is no note recording the causes of death against the names of both Dr Bailey and Dr Gill as there is for Ms Bennett. The objective evidence, accordingly, is not sufficient to lead to the inference of Dr Gill's involvement in the falsification of Ms Podio's death certificate.

712 Nevertheless, from the evidence I draw the inference that both Mr Herron and Dr Gill were involved in the falsification of death certificates – Ms Francis by Mr Herron and Ms Bennett by Dr Gill.

713 Accordingly, if conveyed, imputation G is substantially true with respect to Mr Herron and Dr Gill.

#### **9.10 Imputation H**

714 Imputation H: The applicant (Mr Herron and Dr Gill), a psychiatrist, lied to his patients' families about how ill the patients were and denied those families visitation.

715 As noted above, imputation H is not conveyed.

716 The applicants contended that:

There is no evidence of this at all. No patient has been identified whose family was said to have been lied to.

This allegation was never put to Dr Gill generally or in relation to any particular patient.

717 The respondents submitted that the evidence established the existence of a general policy of lying to patients about the condition of their relatives and denying visiting rights which it should be inferred applied equally to the DST patients of Mr Herron and Dr Gill. In particular, the general practices and procedures at Chelmsford for DST patients were enforced by the

nurses and did not depend significantly on which doctor's patients were being treated at any particular time.

718 The evidence included the following.

719 In the *Hart v Herron* proceedings, Mr Herron stated the position in relation to visitors as follows (Ex. 49, Tab 10):

We did not have any visiting because the chance of the person being awake to the degree of being reasonable to visit is fairly random. It usually inconveniences the relatives for no return.

720 Ms Bothman said (Bothman [55] CB2 AFF0001, p 12):

To the best of my recollection, I was given strict orders that patients were not allowed to have visitors while they were in the Sedation Wards. I cannot remember who gave those instructions, but they applied to all patients regardless of the treating doctor.

721 While she was asked about visitors in the general ward in cross-examination, her evidence about no visitors to the DST ward was not challenged.

722 The evidence of other nurses was also to the effect that visitors were not allowed in the DST ward: Townsend p 194 (CB12 HN0144); Adams pp 26-27 (CB3 HN0001).

723 The respondents also noted:

Ms [CO], Mr Nam and GW provided evidence of the no-visitor policy, from the perspective of family members. Ms [CO] was told 'You're not allowed to see him while he's in sedation, it's out of bounds'. Later on, when she was lost in hospital and pushed on the door to the sedation ward she was told 'You are not allowed in there'. She sat around at the hospital for the whole day while seeking to visit her husband and was told on multiple occasions 'It's doctor's orders, you can't see sedation patients'. Mr Nam was told not to come in and see his wife while she was in sedation and instead, to see Dr Bailey on Thursday night in Macquarie St. After following those instructions, Mr Nam visited Dr Bailey and was bluntly told that his wife had died. GW provided evidence of her mother that 'I came to Chelmsford when you were being treated there, but they wouldn't let me see you'. Similar evidence was provided by other patients and family members.

The nurses' notes record that even the father of a 13 year old girl was to be discouraged from visiting his daughter while she was being treated at Chelmsford: MED00055.24 (RTB6).

724 It must also be inferred from the evidence that there was a deliberate policy of not informing relatives of complication arising during DST. The respondents pointed to various examples.

Peter Clarke was admitted to Chelmsford on 16 February 1974. His wife came and visited him later that day and after an incident where Mr Clarke broke the restraints which were holding him and threw a wardrobe, Mrs Clarke was told 'Right, get out and don't come back': Clarke pg. 33 (CB4 HN0022). After that time, Mrs Clarke rang

every day and night and was told not to go near her husband ‘because he was resting’: Clarke pg. 33 (CB4 HN0022). On 22 February she rang the hospital again and was told Mr Clarke was ‘doing well’: Clarke pg. 34 (CB4 HN0022). Four hours later, Dr Bailey called to tell her that Mr Clarke had died: Clarke pg. 34 (CB4 HN0022).

Mr Clarke’s medical notes at Chelmsford show that he was not doing well throughout the period 16-22 February 1974. He was in and out of sedation as various complications arose. At various points he was very mucousy and had an elevated temperature, with the nurses notes indicating ‘Pt does not look well’: MED000148.18 (RTB8). Yet Mrs Clarke was not told about any of this, but was instead told as late as 22 February that Mr Clarke was ‘doing well’.

725 Mr Hart’s mother and sister were told he was sleeping and not to be disturbed when in fact he was severely ill during DST with multiple complications as already described.

726 As the respondents said:

[RCO] suffered numerous complications across three DST admissions in October 1977, February 1978 and September 1978:

- (a) In October 1977, [RCO] became febrile, hypertensive, had shallow respiration and was coughing blood;
- (b) In February 1978, [RCO] suffered from elevated temperatures, rapid and shallow respiration, thick, coffee-ground stained and bright red blood-stained aspirate, exhibited thick yellowish grey mucous, and had a distended abdomen; and
- (c) In August 1978, [RCO] suffered from elevated temperatures, rapid and shallow respiration, dark blood-stained fluid, exhibited thick frothy mucous, was coughing and vomiting blood, had a distended abdomen and had discolouration of skin after ECT requiring the administration of ECT.

Despite these complications, when Ms [CO] called to ask how her husband was going, she was told you can’t talk to Dr Bailey: [CO] [35] (CB2 AFF0008, pg.5-6).

727 Based on this evidence I accept that it must be inferred that there was a general policy which was adopted by all of the doctors involved in DST that patients were not to have visitors while under DST and that their families were not to be informed about complications arising during DST including, if necessary, lying to the family by telling them the patient was asleep or doing well when in fact they were suffering from one of the many known complications of DST. In a small hospital such as Chelmsford Mr Herron and Dr Gill must have been actively complicit in the existence and enforcement of such a policy.

728 Accordingly, if conveyed, imputation H is substantially true with respect to Mr Herron and Dr Gill.

## 9.11 Imputation J

729 Imputation J: The applicant's (Mr Herron's and Dr Gill's) gross negligence as a psychiatrist  
caused the death of many of his patients.

730 As noted above, imputation J is not conveyed.

731 The applicants submitted:

### Mr Herron

The only patient of Dr Herron who died was Audrey Francis.

Dr Phillips conceded that there was nothing in her symptoms before her death indicating that she was unwell.

No issue of gross negligence has otherwise been identified. The administration of DST was an accepted practice that had occurred at [Chelmsford] for 13 years before Dr Herron treated Audrey Francis.

No other patient of Dr Herron's died at [Chelmsford]. It is an essential part of this imputation for the respondents to prove 'many deaths'. The concept of many deaths clearly differs in substance to one death.

### Dr Gill

The only patient of Dr Gill who died was John Adams.

There is no expert evidence to support a conclusion of gross negligence. At the time of his death Mr Adams was on a drug withdrawal programme. He was not receiving DST or ECT.

There is no evidence that the programme used by Dr Gill was not acceptable at the time.

As to whether the treatment caused death, this is dealt with in detail in Schedule 3.

No other patient of Dr Gill's died at [Chelmsford]. It is an essential part of this imputation for the respondents to prove 'many deaths'. The concept of many deaths clearly differs in substance to one death.

732 For the reasons given above I do not accept that Dr Gill did other than administer DST to John Adams. Further, DST caused Mr Adams' death. Similarly, DST administered by Mr Herron caused the death of Ms Francis. The administration of DST to these patient was grossly negligent for the reasons I have already identified. On the evidence, there can be no real doubt that narcosis therapy of any kind was by the 1960s an experimental and largely abandoned treatment. DST was an experimental form of an experimental treatment and unproven. DST was exceptionally dangerous and not indicated for any psychiatric condition. It had no proven benefit. As practised at Chelmsford the doctors abandoned responsibility for drug administration to the nurses who were unqualified to do what they were doing. Despite the dangers there was no doctor on duty and the equipment and setting was inadequate to provide

the kind of intensive care these patients required. ECT was administered to DST patients without an anaesthetic, oxygen and a muscle relaxant contrary to accepted standards at the time. The so-called treatment of DST caused patients to suffer long-term serious adverse consequences described as long and short-term memory loss, changes in personality, anxiety, depression, respiratory issues, sleeping issues, learning difficulties and migraines. On the evidence, 23 deaths were caused by DST. All of this involved continuing gross negligence by Mr Herron and Dr Gill. They must have been wilfully blind to the harm which they were involved in perpetrating – both by administering DST to patients and in Mr Herron’s case by subjecting Dr Bailey’s DST patients to ECT (as a result of which these patients were also, in truth, Mr Herron’s patients) and in Dr Gill’s case by enabling DST to continue to be provided at Chelmsford when he had the power to stop it in his role as de facto manager of the hospital by informing his fellow owners that it could not continue to be safely provided at the hospital. As a result of these facts, by their conduct, Mr Herron and Dr Gill materially contributed to (that is, caused) the death of many patients at Chelmsford from DST. They were integral parts of a system or pattern of conduct that enabled the administration of DST and ECT at Chelmsford to continue. This is sufficient to make imputation J, if conveyed, substantially true with respect to Mr Herron and Dr Gill.

## 9.12 Imputation K

733 Imputation K: The applicant (Mr Herron and Dr Gill), a psychiatrist, engaged in sustained medical malpractice and abuse of his patients.

734 As noted above, imputation K is not conveyed.

735 The applicants submitted:

The use of DST on patients could not be considered malpractice given the literature, the long term use by Dr Bailey and the fact that it worked (or at least - it has not been proved that it did not work).

No abuse of patients was ever put to Mr Herron/Dr Gill. It is not clear who these ‘patients’ are alleged to be.

736 I disagree. As already explained, the administration of DST by Mr Herron and Dr Gill to their patients and the administration of ECT by Mr Herron to DST patients without an anaesthetic, oxygen or a muscle relaxant constituted sustained medical malpractice and abuse of patients.

737 Imputation K, if conveyed, is substantially true with respect to Mr Herron and Dr Gill.

### 9.13 Imputation L

738 Imputation L: The applicant (Mr Herron and Dr Gill), a psychiatrist, defrauded his patients' health funds.

739 As noted above, imputation L is not conveyed.

740 The applicants (who did not dispute that Mr Herron overcharged his patients and the Commonwealth for anaesthetic that he did not provide in the period 1973 to 1978) submitted that to prove fraud, knowledge on the part of Mr Herron needs to be proved – recklessness is insufficient because the word “defrauded” has to be given its natural and ordinary meaning, not its legal meaning. They contended that any ordinary person would understand fraud to mean serious criminal conduct involving dishonesty: see *Junius v Messenger Press* [1999] SASC 99 at [240].

741 The applicants noted that the alleged amount of over-claiming in 1991 terms was only about \$2,000 over six years. Given that Mr Herron throughout this period was a qualified medical specialist, there was no evidence of significant financial motive.

742 According to the applicants:

- (1) with the number of patients he was administering ECT it would have been impossible for Mr Herron to keep track or remember which patients were administered ECT in the general ward or sedation ward, and which DST patients (like Ms Francis) received an injection of anaesthetic while under sedation;
- (2) Mr Herron relied upon handwritten documents that the Chelmsford staff prepared to give to his wife: Ex. 48 p 1521. The sheets in evidence were rudimentary and did not obviously identify which patients received an injection of anaesthetic: see Green CFR00001.3; Dawson CFR00006.3; Hooper CFR00008.3; Collins CFR00021.3. The opportunity for mistake was great;
- (3) the respondents have not tendered all the financial records from the time period. It is necessary to do so to draw a serious inference of fraud by excluding the inference of mistake;
- (4) Mr Herron's position has always been that if a claim was made for a service to which he was not entitled it was a mistake: see Ex. 48 p 1525;
- (5) the respondents have alleged a so-called fraudulent agreement between Mr Herron and Dr Gardiner for Mr Herron to charge only ECT for some patients and Dr Gardiner to

charge only anaesthetic for those same patients. It appears that the respondents have misunderstood Mr Herron's answers to the Royal Commission; and

- (6) at the Royal Commission (Ex. 48 p 1535), Mr Herron clearly stated "I know of no such arrangement." in answer to a question "[w]as there any arrangement between yourself and Dr Gardiner whereby Dr Gardiner would bill a DST patient for anaesthetic treatment and you would bill the same patient for ECT treatment?". It appears that the respondents rely upon an answer given further down p 1535 but it is clear from the cross-examination that followed Mr Herron's denial of any knowledge or involvement with an arrangement or agreement with Dr Gardiner on the terms alleged. On p 1537, Mr Herron answered "[n]o" to the questions "[y]ou and he had come to an agreement that he would claim anaesthetic and you would claim ECT?" and "[t]hat is, that you had come to an agreement?". Mr Herron's evidence in this proceeding (T2612) acknowledging an arrangement was not in relation to the allegations the respondents make but the fact that he had some financial relationship with Dr Gardiner that he cannot now recall: see AFF000F [88]. Mr Herron denied that there was any such arrangement as alleged by the respondents: T2617.7-10.

743 The applicants also submitted:

The truth of this imputation was withdrawn by the respondents after they finished cross-examining Dr Gill. The pleading of this allegation when there was no basis to allege this serious matter is also a ground for aggravated damages.

744 It follows that imputation L, if conveyed, is not substantially true in respect of Dr Gill.

745 In respect of Mr Herron, the respondents noted that it is not in dispute that Mr Herron overcharged his patients and the Commonwealth for anaesthetic that he did not provide in the period 1973 to 1978. The total amount of overcharging by 1991 was around \$2,000, in 1991 dollars: Herron XXN at T2564.23-24.

746 The respondents said:

At common law fraud is an act or omission done knowingly, without belief in its truth, or recklessly: *Derry v Peek* [1889] UKHL 1; (1889) 14 App Cas 337 at 374.

747 The respondents summarised the relevant evidence as follows.

Mr Herron's evidence was that he picked up documents from Chelmsford and gave them to his wife: Herron XXN at T2594.43-2595.3.

In the Royal Commission, Mr Herron accepted that any handwritten variation made by his wife to the accounts to include a charge for anaesthetic must have been in response



to instructions from him: Ex. 48, Tab 16, pg. 1523. In the present proceedings, Mr Herron sought to distance himself from that answer on the basis that his memory had changed since the Royal Commission: Herron XXN at T2588.16-17.

However, Mr Herron accepted that he gave Mrs Herron some guidance about whether or not anaesthetic had been given: Herron XXN at T2597.26-31.

He also stated when shown CFR00002 (RTB1) that the instructions about what to charge for would have come from the person who is charging, which he thought was Dr Gardiner: Herron XXN at T2592.35-36. In fact the records indicate that the person charging, who administered the ECTs, was Mr Herron: CFR00002.4, 6, 7, 9, 10, 11 (RTB1). This is an example of Mr Herron taking every opportunity to deflect responsibility for matters that occurred at Chelmsford. The patient was his (CFR00002.4 RTB1) and he administered the treatment. On Mr Herron's own evidence, the instructions to Mrs Herron about what to charge must have come from him.

It beggars belief to think that this overcharging was an oversight. Mr Herron was responsible for picking up the handwritten note from the station, which his wife Margaret could then use to know what to charge on the accounts. Mr Herron accepted that he was the only source of information for his wife's record keeping.

Mrs Herron was a competent secretary: Herron 2 [90] (CB2 AFF000F). Mr Herron was the person responsible for informing Mrs Herron of what services were carried out and what to charge. It is inconceivable that Mrs Herron would make claims for anaesthetic unilaterally without her husband's involvement.

Mr Herron's evidence is that there were many occasions where he performed ECT on DST patients at Chelmsford without anaesthetic: Herron 2 [90] (CB2 AFF000F). When trying to justify the charges made for anaesthetic with ECT, he stated that on those occasions he was quite sure that he had administered it: Herron XXN at T2598.19-20. However, the evidence shows that Mr Herron routinely charged for anaesthetic and ECT in circumstances where he did not administer it. This is a further reason to disbelieve Mr Herron's evidence on this topic.

In those circumstances, the Court can be satisfied that the errors which continued over a period of years were such that Mr Herron knew about them. If the Court is not satisfied that proof of actual knowledge has been established then he was clearly reckless in his actions by not turning his mind to, or checking, whether or not he should be routinely charging patients for anaesthetic in circumstances where he knew that ECT was often given to DST patients at Chelmsford without anaesthetic.

748 Further, the respondents said, Mr Herron had an arrangement with Dr Gardiner under which he paid Dr Gardiner a sessional fee for his visits to Chelmsford, irrespective of whether he saw Dr Bailey or Mr Herron's patients: T2601.46-2602.2. Where Dr Gardiner provided services to Mr Herron's patients, Mr Herron paid him a fixed amount for each visit: Ex 48, Tab 16, p 1530. Dr Bailey paid Mr Herron for services provided by either Mr Herron or Dr Gardiner to Dr Bailey's patients, and where the service was provided by Dr Gardiner, Mr Herron kept a small amount of that fee and he paid the rest to Dr Gardiner: Ex 48, Tab 16, p 1533. Mr Herron could not remember that arrangement when asked about it in these proceedings: Herron XXN at T2604.27-2605.12. According to the respondents:

Mr Herron knew that his wife was preparing claims for Dr Gardiner: Herron XXN at T2607.1-3. He claimed that Dr Gardiner spoke to Mrs Herron independently of him to discuss these matters (Herron XXN at T2602.29-30) but accepted that he signed the cheques to pay Dr Gardiner: Herron XXN at T2603.16-30.

At the Royal Commission, Mr Herron stated that he assumed Dr Gardiner gave ECT to DST patients without anaesthetic: Ex. 48, Tab 16, pg. 1520. He was therefore aware that, at least in most cases, no claim should be made for anaesthetic where Dr Gardiner administered ECT.

Mr Herron accepted at the Royal Commission that he came to an arrangement with Dr Gardiner whereby when ECT was administered to DST patients, Dr Gardiner would claim for the anaesthetic item charge and Mr Herron would claim for the ECT item charge: Ex. 48, Tab 16, pg. 1535. During cross-examination in these proceedings Mr Herron could not remember the details of the arrangement (Herron XXN at T2607.46-47 and T2608.18-24) but accepted there was some sort of arrangement between him and Dr Gardiner: Herron XXN at T2612.11-12.

Mr Herron's evidence about his arrangement with Mr Gardiner to the Royal Commission was given closer in time to the events in question and should be preferred. This is particularly so in light of the fact that the alternative arrangement was that Mrs Herron, of her own volition and without instructions, submitted claims for anaesthetic for Dr Gardiner and ECT for Mr Herron. For the reasons set out above, this should be rejected.

749 Given the confusion in the evidence I am not persuaded that I can infer the existence of a fraudulent arrangement between Mr Herron and Dr Gardiner. However, the evidence about Mr Herron's routine charging for anaesthetic in relation to ECT in circumstances where he mostly did not administer anaesthetic to DST patients is in a different category. Mr Herron must have instructed his wife to submit charges for anaesthetic. He knew he administered many ECTs without anaesthetic. It is impossible to believe that Mr Herron did not know that he was charging over many years for anaesthetics which had not been administered. The inference of dishonest intent must be drawn. The evidence is sufficient to satisfy me that imputation L, if conveyed, is substantially true with respect to Mr Herron. As noted, it is not substantially true with respect to Dr Gill, which the respondents accept.

#### **9.14 Imputation M**

750 Imputation M: The applicant (Mr Herron and Dr Gill), a psychiatrist, traumatised many of his patients by giving them deep sleep therapy without their consent.

751 As noted above, imputation M is not conveyed.

752 The applicants submitted that:

There is no persuasive evidence that patients were traumatised. Confusion after ECT or after being unconscious is a common side-effect. It does not amount to trauma.

Each of the patients who gave evidence in these proceedings should not be accepted - they were discredited in their accounts by the [Chelmsford] records. Some of the evidence that they gave was so outlandish as to be absurd given the content of the documents. Their evidence is dealt with in Schedule 4 and their credit dealt with in Schedule 5.

The onus is on the respondent to prove the patients did not consent. There is no onus on the applicants to prove patients consented.

As to the patients who were not available, their accounts were also of no probative value. There are many examples of this - John Kerekes being a good one. Each of them is considered, by reference to their [Chelmsford] records, in Schedule 4.

753 As found above, I am satisfied that DST patients did not give informed consent to the procedure. To give informed consent they would have to have been informed of the risk of death and serious complications associated with the procedure (as well as the existence of safer and proven to be efficacious alternatives) and I consider it highly implausible that any of the doctors involved in its administration (Dr Bailey, Mr Herron and Dr Gill) were willing to make this kind of disclosure. In effect, the very process of obtaining informed consent would have ensured that no patient was willing to undergo the procedure. It must be inferred, accordingly, that each of the doctors (Dr Bailey, Mr Herron and Dr Gill) were involved in administering a highly dangerous procedure to their patients without their consent. From the evidence, it must be inferred that there was a deliberate policy of describing DST to patients, if at all, in misleadingly euphemistic terms (such as a nice sleep or rest) without any reference to the risks or side effects involved. This effectively ensured that no patient could give meaningful consent to DST.

754 There is also ample evidence that many patients were traumatised by their experiences at Chelmsford. As the respondents noted:

There is overwhelming evidence of ongoing issues for patients following DST at Chelmsford. Among a litany of complaints, patients suffered long and short-term memory loss, changes in personality, anxiety, depression, respiratory issues, sleeping issues, learning difficulties and migraines. For many patients, the treatment took away part of their life and is something they have spent their lives struggling to overcome.

It is unsurprising that patients found DST and its aftermath so harmful and distressing considering the complications suffered by many of them during the treatment. Amongst more serious complications, such as the onset of pneumonia and respiratory distress, patients suffered bedsores, high temperatures, cyanosis, breathing difficulties, vomiting, aspiration of dark stomach fluid, distended abdomens and bladders and serious blood pressure issues. Dr Phillips' conclusion is that the interaction between the various psychotropic agents that made up the DST regime could not have been predicted and that by administering it to his patients, including Ms BF, Ms BH and Ms JW, Mr Herron put them at risk of significant side-effects.

The Applicants can be expected to point to the unreliability of this evidence from

patients, in light of the fact that it is not in dispute that hallucinations were one of the well-known side-effects of the treatment. If this case were only about one or two examples of the treatment described in this section, that submission might be accepted. But the sheer volume and variety of complaints from patients and loved ones demonstrates that this cannot just be a put down to side-effects which were known and accepted by patients. Rather, it was part and parcel of the mistreatment of patients which occurred in the DST ward at Chelmsford. DST was not only dangerous, it was dehumanising. It was appalling that patients were subjected to its horrors, particularly considering the complete lack of objective evidence as to any benefits.

755 The applicants' submissions to the contrary are unrealistic and dismissive of a wealth of evidence about the ongoing trauma many former patients of DST have had to contend with throughout their lives. In my view, the very nature of DST was dehumanising and traumatising. Patients and their families were not informed about what was proposed. Patients were rendered effectively comatose for no good reason, for lengthy periods, making them defenceless, helpless, and incontinent. While sedated they were subjected to ECT without anaesthetic, oxygen or muscle relaxants. While sedated they were at serious risk of serious complications and many of them became ill to some or other extent. Their family was kept in the dark about what was happening to them. On becoming conscious, the patients were naturally distressed, scared, confused, weak, and debilitated. Their vulnerable condition was exacerbated by the side effects of the barbiturates used, including hallucinations.

756 Accordingly, if conveyed, imputation M is substantially true with respect to Mr Herron and Dr Gill.

## **9.15 Conclusion**

757 All of the imputations which I have concluded are conveyed are substantially true. Of the imputations which I have found are not conveyed all are also substantially true other than alleged imputation L that Dr Gill defrauded patients' health funds. Accordingly, the applicants' claims must fail.

## **10. QUALIFIED PRIVILEGE**

### **10.1 Principles**

758 Section 30 of the Act provides that:

- (1) There is a defence of qualified privilege for the publication of defamatory matter to a person (the '**recipient**') if the defendant proves that-
  - (a) the recipient has an interest or apparent interest in having information on some subject, and
  - (b) the matter is published to the recipient in the course of giving to the

recipient information on that subject, and

- (c) the conduct of the defendant in publishing that matter is reasonable in the circumstances.

...

- (3) In determining for the purposes of subsection (1) whether the conduct of the defendant in publishing matter about a person is reasonable in the circumstances, a court may take into account--

- (a) the extent to which the matter published is of public interest, and
- (b) the extent to which the matter published relates to the performance of the public functions or activities of the person, and
- (c) the seriousness of any defamatory imputation carried by the matter published, and
- (d) the extent to which the matter published distinguishes between suspicions, allegations and proven facts, and
- (e) whether it was in the public interest in the circumstances for the matter published to be published expeditiously, and
- (f) the nature of the business environment in which the defendant operates, and
- (g) the sources of the information in the matter published and the integrity of those sources, and
- (h) whether the matter published contained the substance of the person's side of the story and, if not, whether a reasonable attempt was made by the defendant to obtain and publish a response from the person, and
- (i) any other steps taken to verify the information in the matter published, and
- (j) any other circumstances that the court considers relevant.

- (4) For the avoidance of doubt, a defence of qualified privilege under subsection (1) is defeated if the plaintiff proves that the publication of the defamatory matter was actuated by malice.

759 The applicants accepted that s 30(1)(a) and (b) are satisfied. The applicants contended that s 30(1)(c) (the conduct of the defendant in publishing that matter is reasonable in the circumstances) is not satisfied and that the defence is defeated by malice as provided for in s 30(4).

760 The respondents submitted that it is necessary to recognise that the defence of qualified privilege assumes the commission of the tort of defamation. That is:

The defence contemplates that, notwithstanding the publication of untrue defamatory matter by the respondent, the respondent's conduct may nevertheless have been reasonable. A finding of fault on the part of the respondent is the very premise on which the defence operates.

761 The respondents referred to *Hockey* at [228] in which White J said:

The matters listed in s 30(3) are not to be regarded as ‘a series of hurdles to be negotiated by a publisher before [it can] successfully rely on qualified privilege’: *Jameel v Wall Street Journal Europe Sprl* [2006] UKHL 44, [2007] 1 AC 359 at [33] in relation to the matters identified in *Reynolds* [*Reynolds v Times Newspapers Ltd* [2001] 2 AC 127] as bearing on reasonableness. It is to be remembered that reasonableness ‘is not a concept that can be subjected to inflexible categorisation’: *Rogers v Nationwide News Pty Ltd* [2003] HCA 52; (2003) 216 CLR 327 at [30]. I also accept the submission of the respondents that reasonableness should not be interpreted as requiring a counsel of perfection, given that the predicate on which it operates is that the imputations in question are not true and that the conduct of the defendant is accordingly not beyond criticism.

762 The respondents observed that the s 30(3) considerations are neither exhaustive nor mandatory. Rather:

What the Court must decide is whether the conduct of the respondent was ‘reasonable in the circumstances’ (s 30(1)(c)). In doing so it may take into account ‘any other circumstances [it] considers relevant’ (s 30(3)(j)).

The Court can have regard to ‘all the circumstances leading up to and surrounding the publication’ and it would be ‘unwise to attempt any comprehensive definition of what they may be’: *Austin v Mirror Newspapers Ltd* [1986] AC 299 at 313 (PC). The factors going to reasonableness will vary with the circumstances of individual cases: *Rogers v Nationwide News Pty Ltd* (2003) 216 CLR 327 at [30] per Gleeson CJ and Gummow J.

763 The respondents also observed that the defence is to the publication of “defamatory matter” (the cause of action in s 8 of the Act being “in relation to the publication of defamatory matter”). Accordingly, the primary focus is the reasonableness of the publication of the defamatory matter, rather than the imputations.

764 As to s 30(3)(h), the respondents referred to the decision of the High Court in *Lange v Australian Broadcasting Corporation* [1997] HCA 25; (1997) 189 CLR 520 at 574 (**Lange**):

Whether the making of a publication was reasonable must depend upon all the circumstances of the case. But, as a general rule, a defendant’s conduct in publishing material giving rise to a defamatory imputation will not be reasonable unless the defendant had reasonable grounds for believing that the imputation was true, took proper steps, so far as they were reasonably open, to verify the accuracy of the material and did not believe the imputation to be untrue. Furthermore, the defendant’s conduct will not be reasonable unless the defendant has sought a response from the person defamed and published the response made (if any) except in cases where the seeking or publication of a response was not practicable or it was unnecessary to give the plaintiff an opportunity to respond.

765 The respondents noted that:

Those comments were made in the context of the consideration of the extended common law qualified privilege given to publications on government and political

matters, which requires the respondent to establish reasonableness of conduct. The requirement of reasonableness of conduct for the purposes of the Lange defence is the same as that for the statutory defence: *Lange* at 572-573. The Court's observations accordingly apply to the question of reasonableness in section 30(3)(h) of the Act.

766 The applicants noted that the onus is on the respondents to prove that their conduct was reasonable. They referred to *Chau* at [107]-[117] per Wigney J (affirmed *Fairfax Media Publications Pty Ltd v Chau* [2020] FCAFC 48 at [188]-[193]). Justice Wigney made the following points:

- (1) the relevance or weight to be given to any one or more of the s 30(3) factors “will very much hinge on the particular facts of the case”: [107];
- (2) “the more serious the imputation that is conveyed, the greater the obligation upon the respondent to ensure that its conduct in relation to the publication was reasonable: *Morgan v John Fairfax & Sons Ltd (No 2)* (1991) 23 NSWLR 374 [*Morgan*] at 387C (per Hunt A-JA, with whom Samuels JA agreed)”: [109];
- (3) “a respondent who intended to convey an imputation that was in fact conveyed must generally establish that they believed in the truth of that imputation and that the imputation conveyed was relevant to the subject: *Morgan* at 387F and 388C”: [110];
- (4) “the fact that the respondent may not have intended to convey the imputation that was in fact conveyed does not necessarily mean that their conduct in publishing was unreasonable ... In such a case, the respondent must generally establish that they believed in the truth of the imputation that they intended to convey, and that their conduct was nevertheless reasonable in relation to the imputation which they did not intend to convey, but which was in fact conveyed”: [111];
- (5) “the respondent must generally establish that reasonable steps were taken before publishing to ensure that the facts and conclusions stated in the publication were accurate”: [112];
- (6) “in relation to sources, the respondent’s belief or perception of the position, standing, character and opportunities of knowledge of the source must be such as to make the respondent’s belief in the truth and accuracy of the information reasonable in the circumstances”: [113];
- (7) “a respondent must show that the manner and extent of the publication did not exceed what was reasonably required in the circumstances”: [115]; and

(8) “the respondent must also establish that the respondent gave the person defamed an opportunity to make a reasonable response to the defamatory imputation”: [115]. His Honour referred to *Lange* at 574 in this regard and, at [116], cited the extract from that case set out above – that is, that the “the defendant’s conduct will not be reasonable unless the defendant has sought a response from the person defamed and published the response made (if any) except in cases where the seeking or publication of a response was not practicable or it was unnecessary to give the plaintiff an opportunity to respond”.

767 The applicants submitted that because the respondents made no attempt to obtain and publish a response from the applicants, the respondents’ case on reasonableness should fail. However, I note that the statement of principle in *Lange*, cited above, is not expressed in such absolute terms. *Austin v Mirror Newspapers Ltd* (1985) 3 NSWLR 354 (*Austin*) at 364 – 365, on which the applicants relied, does not express a statement of general principle. Similarly, *John Fairfax Publications Pty Ltd v Zunter* [2006] NSWCA 227 (*Zunter*) at [30] says only that a “publisher who publishes serious allegations as fact without having checked with the person concerned is taking the risk that they cannot be justified”. *Hockey* at [373]-[374] cites *Lange* at 274 and otherwise turns on its own facts. In other words, the relevant principle is that stated in *Lange* at 274.

768 The applicants also submitted as follows:

Harper Collins [sic] did not tender any evidence relevant to its own conduct. Being a corporation, it can only act through its employees or agents, and the enquiry into the reasonableness of its conduct must therefore focus on the conduct of its employees or agents who were responsible for publication of the matter: *John Fairfax Publications Pty Ltd v Zunter* [2006] NSWCA 227 at [12] per Handley JA. No editor or other employee of Harper Collins was called to give evidence. Since Mr Cannane is not an employee or agent of Harper Collins, his conduct cannot determine the defence for Harper Collins. The reasonableness of Harper Collins’ conduct depends on the conduct of the editor or other employee who determined that the matter complained of should be published by the company: *Morgan v John Fairfax & Sons Pty Ltd* (1991) 23 NSWLR 374 at 382 per Hunt AJA.

Whatever the Court finds in relation to Mr Cannane, there is no evidence that HarperCollins itself behaved reasonably in publishing the matter complained of. Its s30 defence must fail due a complete lack of evidence of reasonableness by it - its state of mind is completely unproved and reasonableness thus cannot be assessed.

769 The respondents disputed this contention. According to the respondents, the cases in question refer to the difference between the employee/agent of a publisher and an independent contributor for the purpose of properly identifying the basis on which a publisher can rely on a



s 30 defence in circumstances where the independent contributor is found to have behaved unreasonably. Both cases depend on the statement in *Austin* at 363 that:

The newspaper, the publisher, cannot be allowed to hide behind their journalist on the ground that it never occurred to them that their journalist would be so careless. The newspaper must stand or fall by the conduct of its own journalists. Very different considerations will of course apply to the publication of an article by an independent contributor who cannot be considered as either the servant or agent of the newspaper. An independent contributor is in no sense the alter ego of a newspaper for the purpose of producing the article and in such circumstances his reliability and reputation will be a very important matter in considering whether the conduct of the publisher was reasonable in accepting and publishing the article if it turns out to be defamatory and untrue.

770 According to the respondents, the present case is different. HarperCollins' defence stands or falls on the reasonableness of Mr Cannane's conduct. As the respondents put it:

HarperCollins does not seek to run a separate case to the effect that it was reasonable for it to have relied on Mr Cannane, in the event of a finding that Mr Cannane had been unreasonable. If, by virtue of all the matters relied on, it was reasonable for Mr Cannane to publish, it cannot seriously be argued that HarperCollins behaved unreasonably in doing so. To put it another way, it is a powerful circumstance making the publication of the book by HarperCollins reasonable.

In any case, the obvious inference from HarperCollins not having served its own specific evidence is that it simply relied on Mr Cannane and made no enquiries or independent steps of its own. That was not unreasonable and the effect is that HarperCollins' qualified privilege defence stands or falls based on Mr Cannane's enquiries.

771 I agree with the respondents' submission. The lack of evidence from HarperCollins does not mean it is unable to rely on the s 30 defence. It means that the inference which should be drawn is that HarperCollins took no steps of its own concerning the reasonableness of the publication and instead relied wholly on the conduct of Mr Cannane. The legal result is not that HarperCollins' defence must fail, but that HarperCollins' defence is wholly dependent on Mr Cannane's defence. To conclude otherwise, as the respondents noted, would lead to the potentially absurd result of a finding that it was reasonable for Mr Cannane to publish the defamatory matter yet not reasonable for HarperCollins to do so in circumstances where the obvious inference is that HarperCollins did no more than rely on Mr Cannane for that purpose.

772 As to s 30(4) and the concept of "malice" the applicants referred to *Roberts v Bass* [2002] HCA 57; (2002) 212 CLR 1 at [75]-[76] and [104] to the effect that "malice" is an improper motive - a motive foreign to the occasion which gives rise to the occasion of privilege and is not to be confused with mere ill will, spite or prejudice. Further, to prove that the publication of the matter complained of was "actuated by" malice, the applicants must prove that the relevant

improper motive was the dominant motive for publication: *Horrocks v Lowe* [1975] AC 135 at 149-151.

## **10.2 Discussion**

### **10.2.1 General**

773 The respondents noted at the outset that:

...the events at Chelmsford Private Hospital, the role of the doctors who practised DST, and the scandal of the treatment offered by them are matters of the social and medical history of New South Wales. The events were the subject of an exhaustive enquiry stretching over two years conducted by an experienced judge, Acting Justice Slattery. For obvious reasons it is impossible to recreate those proceedings in a six-week court case. It would be grotesquely disproportionate to attempt to do so.

774 I agree. The applicants' case proceeded as if the Royal Commission had never occurred and its report had never been published. If the applicants acknowledged the Royal Commission it was merely to contend either that the Acting Justice Slattery had been effectively duped into accepting a Scientology version of events or that the applicants had been subjected to a serious injustice by Acting Justice Slattery. Neither contention is realistic. The Royal Commission report was entitled to be treated by Mr Cannane as a definitive account of the appalling events which had occurred at Chelmsford. The Chapter was intended to expose the role of Ms Nicholson, a Scientologist, in ensuring that Chelmsford was itself exposed – a matter which had not been the subject of attention during the Royal Commission. It was not intended to investigate any supposed shortcomings in the Royal Commission report.

775 As the respondents submitted, it was eminently reasonable for Mr Cannane to rely on the findings of Slattery AJ. The applicants' approach to the case, as if the Royal Commission report did not exist and could not be reasonably relied upon, is without merit.

### **10.2.2 Section 30(3) factors**

776 Section 30(3)(a): the matter published is of public interest. As the respondents submitted, the events at Chelmsford and the resulting Royal Commission are a matter of public interest because they were significant events in the history of the practice of psychiatry in New South Wales: McGorry [7]-[9] (CB2 AFF0006, pp 3-4). The public interest in Chelmsford has not ceased by reason of the passage of time. The events at Chelmsford are part of a "deeply shameful aspect of the history of psychiatry": McGorry [9] (CB2 AFF0006, p 3).

777 Section 30(3)(b): the applicants do not have a public function.

778 Section 30(3)(c): the pleaded imputations are serious.

779 Section 30(3)(d): as discussed below, Mr Cannane relied heavily on findings of the Royal Commission report. He was entitled to treat those findings as proven facts.

780 Section 30(3)(e): the public interest did not require expeditious publication.

781 Section 30(3)(f): as the respondents submitted, Mr Cannane’s chasing down the true story of the contribution made by Ms Nicholson to the exposure of the iniquitous goings-on at Chelmsford was a worthwhile endeavour that has increased, not reduced, the total sum of human knowledge. In the respondents’ words:

...the publishing of books, especially dealing with serious matters of public interest of the kind dealt with here, is of great public benefit. Literacy and the encouragement of reading are fundamental values that contribute to the health of any society. The Court is entitled to take into account that in the publication of this book, the respondents are part of that fundamentally worthwhile project, and the benefit that the project generates.

782 Section 30(3)(g): Mr Cannane used extensive sources and cross-checked their evidence to the findings of the Royal Commission.

783 Section 30(3)(h): Mr Cannane chose not to seek the applicants’ “side of the story” although he accepted he could have done so. Relevant to the reasonableness of that conduct is the fact that the applicants had been involved in the extensive hearings of the Royal Commission and their “side of the story”, which had been given at length during the Royal Commission, had been resoundingly rejected in the most strenuous of terms by Slattery AJ. As the respondents noted, the Royal Commission made damning findings about the honesty and credibility of the applicants.

784 As to Mr Herron, the Royal Commission said:

Dr Herron was an unsatisfactory witness. He was a man who clearly knew much but was prepared to reveal little either in terms of facts or in terms of expertise or opinion. In my view he deliberately concealed knowledge about a number of patients who died at the hospital. ...

I think there are large parts where he has deliberately concealed the truth. Indeed in the 29 days of his evidence, he only provided factual information in situations where it was clear the information would be available from other sources. Further, when he provided that information, he provided it in a manner which concealed the truth. There were times when his answers became almost incomprehensible.

785 As to Dr Gill, the Royal Commission said:

In summary, Dr Gill was a most unsatisfactory witness. He was prepared to lie when

the occasion demanded. He obstinately continued his delusional attacks on innocent people in the witness box in the face of clear evidence that he was wrong. He was prepared to involve himself in the falsification or removal of records if his interests were threatened.

786 It was reasonable for Mr Cannane to rely on those findings. It was reasonable for Mr Cannane to conclude (as he did) that he would have “zero confidence that they would tell the truth” so that it would have been a “waste of time” speaking to the applicants: Affidavit of Stephen Cannane dated 3 October 2019 (**Cannane 1**) [172(cb)] (CB2 AFF0003, pp. 34–35).

787 Further, the matters in the Chapter not based on the Royal Commission findings concerned Mr Hart. As the respondents submitted:

Mr Cannane was aware of the jury’s findings in respect of Mr Herron in *Hart v Herron*. Again, it was reasonable for Mr Cannane to conclude that he did not need to speak to Mr Herron about those matters. As to Mr Hart’s personal experiences at Chelmsford, the best source for those was Mr Hart himself: Cannane XXN at T719.19-25. In circumstances where Mr Herron was not present at Chelmsford when Mr Hart was admitted, there is little that Mr Herron could have added. In light of the Royal Commissioner’s finding that Mr Herron gave misleading evidence about Barry Hart’s consent form and had been a party to the 1977 conversation to create a false form, it was again reasonable for Mr Cannane to consider that any response that Mr Herron might have provided in respect of Mr Hart was unlikely to be truthful: OTH00010.188, pg. 180ff (RTB11).

788 Section 30(3)(i): as noted, Mr Cannane cross-checked his various sources with the Royal Commission findings.

789 Section 30(3)(j): other circumstances are considered in the balance of this section.

### **10.2.3 Respondents’ response to criticisms of Mr Cannane**

790 The respondents’ submissions about the issues put to Mr Cannane during cross-examination are cogent and convincing.

791 As the respondents submitted, the Royal Commission hearing went for 21 months, involved hundreds of lay witnesses, and dozens of expert witnesses. The applicants each gave lengthy evidence during the Royal Commission and each was known by Mr Cannane to have been represented by eminent senior counsel. Each applicant had been found to be an opportunistic liar. In these circumstances the respondents are right to say that for Mr Cannane, acting reasonably, there was no better arbiter of the truth of what occurred at Chelmsford than Slattery AJ.

792 The fact that disciplinary and criminal proceedings against the applicants were stayed does not mean that Mr Cannane was not entitled to rely on the findings of the Royal Commission. The

stays of criminal and disciplinary proceedings were a result of the passage of time. No substantive findings contrary to those of the Royal Commission have ever been made.

793 As the respondents put it:

Moreover, the evidence both at the Royal Commission and in these proceedings is that there is a professional medical consensus in respect of DST: that it was outdated, dangerous and should never have been practiced at Chelmsford. Whether proceedings against the Applicants were stayed or not, there was no single medical professional at the Royal Commission who supported the use of DST at Chelmsford, despite Mr Herron nominating his own experts for those proceedings: Ex. 49, Tab 18. It is disingenuous to suggest that the Applicants were somehow greatly wronged by the findings of the Royal Commission, and then vindicated by proceedings against them being stayed. If that was the case, they would have led medical evidence in these proceedings about why Justice Slattery was wrong. They did not and the expert evidence in these proceedings supports the findings of Slattery AJ.

794 Mr Cannane relied on interviews with Mr Hart for facts concerning his treatment at Chelmsford and the impact it had on his life: Cannane 1 [71] (CB2 AFF0003, p 18). It was reasonable for Mr Cannane to rely on interviews with Mr Hart who was the most reliable source for his experiences at Chelmsford. It was not irresponsible for Mr Cannane not to mention the appeal by Mr Hart in *Hart v Herron* which was an appeal against only the damages awarded to him. As the respondents said, the jury findings regarding Mr Herron's treatment of Mr Hart, which Mr Herron himself told the Royal Commission were devastating to him professionally (Ex 47, [16]-[18]), were never challenged and never overturned.

795 Mr Cannane did not simply take what Mr Hart said at face value. Mr Cannane cross-checked what Mr Hart told him against the Royal Commission report, the judgment in the appeal in *Hart v Herron*, previous statements by Mr Hart, and other relevant documents. In any event, Mr Cannane is an experienced and awarded journalist, who formed the view based on that experience that Mr Hart was truthful: Cannane 1 [71] (CB2 AFF0003, p 18). As the respondents also submitted, the findings the Royal Commission made about DST generally are consistent with Mr Hart's experience of DST at Chelmsford, namely:

- (a) DST was a very dangerous procedure: OTH00008.4 (RTB10);
- (b) Mr Herron was involved in concealing the whole truth from his patients of what DST involved: OTH00009.90 (RTB11);
- (c) DST patients at Chelmsford were not told about the treatment, its side effects or potential after effects prior to commencing treatment: OTH00009.64-5 (RTB11);
- (d) DST patients were routinely shackled and suffered hallucinations: OTH00009.64.5 (RTB11);

- (e) Many DST patients suffered severe complications because of the treatment: OTH00009.98 (RTB11);
- (f) DST patients were rarely given a physical examination prior to commencing the treatment: OTH00009.99 (RTB11);
- (g) The DST drug regime was dangerous and involved a very significant risk of cardio-respiratory, cardiovascular and neurological complications: OTH00007.13 (RTB10);
- (h) Many DST patients received ECT without giving their consent to it: OTH00010.71 (RTB11); and
- (i) DST was a radical, lengthy and dangerous procedure: OTH00010.103 (RTB11).

796 Mr Cannane was correct to observe that Mr Hart was the only source of information about how he felt when he became conscious after DST. To the extent medical records are available, they support Mr Hart's evidence that he was seriously ill during and after DST.

797 It was not unreasonable for Mr Cannane not to interview Mr Dilworth or read his evidence from the Royal Commission. As the respondents submitted:

Mr Dilworth admitted both in *Hart v Herron* and at the Royal Commission that he in fact had no memory of explaining the treatment to, or obtaining consent from, Mr Hart. Presumably this is why the jury in *Hart v Herron* found that Mr Hart had been given DST and ECT without his consent, a matter referred to by Mr Cannane in response to this particular attack (Cannane XXN at T717.20-8). The jury in *Hart v Herron* were in a much better position to assess Mr Dilworth's evidence than Mr Cannane could ever be and they accepted Mr Hart's evidence that the treatment was never explained to him, by Mr Dilworth or otherwise.

798 As the respondents also submitted, there was no material discrepancy between what Mr Hart told the Royal Commission and a speech he gave in the Green Left Weekly. As the respondents noted:

The Green Left Weekly speech put to Mr Cannane reads *I arrived...and asked to see a psychiatrist – who I never saw* (T792.33-35). Mr Hart does not say in the speech that he had not seen Dr Herron previously, only that he asked to see him on arrival at Chelmsford and he was not seen by him. That is consistent with the story told in the Book and what Mr Hart said under oath at the Royal Commission. Mr Hart, while conscious, never saw Dr Herron from the time of his admission until he was in Hornsby Hospital.

799 I do not accept that it was unreasonable of Mr Cannane not to read Ms Fawdry's evidence in the Royal Commission or test her evidence about the 1977 meeting in which the applicants discussed how to cover-up Mr Hart's missing consent form. Ms Fawdry's evidence to Mr Cannane is consistent with what she told the Royal Commission and was accepted by Slattery AJ. Mr Cannane had no reason to disbelieve Ms Fawdry.

800 It was not unreasonable for Mr Cannane not to investigate whether Ms Bothman was a Scientologist. The allegation is entirely unfounded. Mr Cannane had no reason to raise the issue with Ms Bothman.

801 The fact that Mr Cannane gave Mr Segal and Ms Eastgate an opportunity to respond to certain matters does not mean his decision not to consult the applicants was unreasonable. The matters put to Mr Segal and Ms Eastgate by Mr Cannane were not the subject of Royal Commission findings. They were new matters discovered by Mr Cannane during his research. Accordingly, there can be no comparison between the two situations.

802 The fact that Mr Cannane did not disclose that the *60 Minutes* broadcast referred to in the Chapter included an interview with Dr Sasz, who was a Scientologist (Cannane XXN at T733), is immaterial. As the respondents put it, to pick one individual from a cast of thousands and assert that the author should have provided more information about that individual does not provide a foundation for any suggested unreasonableness.

803 It was not unreasonable for Mr Cannane to refer to an unreferenced book (Bromberger B and Fife-Yeomans J, *Deep Sleep: Harry Bailey and the Scandal of Chelmsford* (Simon & Schuster, 1991)) and the Geason Manuscript as sources for the Chapter: Cannane XXN at T726. As the respondents submitted:

There can be no criticism of Mr Cannane for familiarising himself with contemporaneous research into matters the subject of the Chapter. The two texts were used for background and, in the case of the Geason transcript, for information from sources who were no longer available: Cannane 1 at [46] and [61] (CB2 AFF0003, pg. 13, 16). This a perfectly ordinary course. It's clear that both texts refer to primary materials, and in any event there is little asserted about the actions of the Applicants that cannot be found in the report of the Royal Commission.

804 As the respondents also put it, the focus of the Chapter was to expose the role of Scientology in bringing to light the medical abuses at Chelmsford. This aspect of the history of Chelmsford had not been disclosed in the Royal Commission. Otherwise, insofar as the applicants are mentioned in the Chapter, Mr Cannane relied on the Royal Commission report. The purpose of the Chapter was not to investigate the Royal Commission's own investigation or to challenge findings which have stood undisturbed for decades. The respondents are correct to assert that Mr Cannane's reasonableness must be assessed through this prism.

#### 10.2.4 Applicants' submission about Mr Cannane

805 I found the applicants' submissions about Mr Cannane's evidence unbalanced, unpersuasive, and in many respects unreliable.

806 Mr Cannane's error about having read the evidence of Mr Hart and Ms Eatts in the Royal Commission does not undermine his credibility. Nor does it support the conclusion that his evidence about his research should be treated with caution. As the respondents submitted, the events are not a cause for concern about the veracity of Mr Cannane's evidence. The State Archives' email to the effect that all the material was available does not undermine the effect of Mr Cannane's evidence that material may or may not be available at State institutions, despite what was said in the email. Further, the fact that he visited the State Archives shows the comprehensive approach he took to his research.

807 I do not accept that much of Mr Cannane's evidence involved reconstruction rather than recollection. Mr Cannane had a remarkably clear recollection of the process he used to write the Book. The fact that he made some errors which he then corrected does not undermine the overall impression he gave as a truthful and reliable witness. The fact that document 9 was created after the event (as Mr Cannane explained) also does not support the applicants' criticisms of Mr Cannane. The fact that he could not recall the details of what he asked his sister to do to collate the extracts from the Royal Commission report is a reflection of his honesty, not his willingness to reconstruct events. He rejected the suggestion that he asked his sister to obtain parts of the document which supported his case (T694.39-40). I accept his evidence.

808 The applicants' submission that Mr Cannane was lying about his telephone calls to Ms Fawdry also cannot be accepted. It may be accepted that Ms Fawdry could not recall the earlier telephone calls and believed Mr Cannane had only called her after the Book had been published but there is no reason to doubt Mr Cannane's evidence in that regard. As the respondents noted, the evidence supporting Mr Cannane's evidence is clear:

Mr Cannane gave evidence of the conversations he had with Ms Fawdry (Cannane 1, [98]-[99]; AFF0003). His notes of that conversation are contained at OTH00060.17-18 (RTB16) and are referred to at paragraph 98 of his affidavit (AFF0003, CB2).

809 Further, Mr Cannane referred in the Chapter to his conversations with Ms Fawdry (pp 180, 184 and 194). This effectively proves the truth of Mr Cannane's evidence that he spoke to her before publishing the Book. It is entirely plausible that Ms Fawdry may have forgotten these



conversations. Contrary to the applicants' submissions she had no particular reason to recall them and plainly did not recall them even though they occurred. She did not deny the conversations at all; she merely could not recall them.

810 Mr Cannane was clear in his evidence that he was not intending to second-guess the findings of the Royal Commission. He said:

Well, I went on what Justice Slattery said. And I think that those terms, atrocities and horrors, when you look at what happened – if you look at the deaths of 24 people from that hospital, the impact that it had on those families with the – who were related to those people who died, I think they were atrocities and horrors.

...

I'm not saying that I wasn't interested in any piece of information; what I'm saying is that I used Slattery J's report to tell the story of what went on there. Now, that was one part of my chapter, and I relied on him. And, I mean, he used terms like 'a catalogue of disaster' to describe what went on at Chelmsford Hospital. And I feel like he is a trustworthy source to the – you know, the authority... I'm just saying, I think he's the authority on what went on there.

811 Given the comprehensive nature of the Royal Commission and its extensive findings, including serious adverse findings about the conduct and dishonesty of the applicants, it was reasonable for Mr Cannane to treat the Royal Commission report as an authoritative source for that part of the Chapter concerned with events at Chelmsford. It is difficult to conceive of a source that an investigative journalist might perceive as more credible or trustworthy. The fact that he described events at Chelmsford as involving atrocities and horrors is because that is what the Royal Commission report found.

812 The applicants referred to the statement on p 179 of the Book of Chelmsford operating like a secretive cult as evidence of Mr Cannane's unreasonableness. However, as the respondents submitted:

It was reasonable for Mr Cannane to rely on the findings of the Royal Commission about matters relating to Chelmsford. This was another matter which was reflected in those findings (OTH0008.100-103 RTB10), including the following [Royal Commission] conclusion:

The evidence satisfies me that virtually from the beginning of the administration of DST and ECT at Chelmsford in 1963, there was a systematic cloak of secrecy about the treatments, a blanket on the disclosure of information relating to it and a fraudulent cover-up of deaths and other incidents at the hospital...

Mr Cannane relied on that description: T750.41-45.

813 The other evidence on which the applicants relied (and which Mr Cannane did not dispute), that DST had been described in coronial inquests, in articles in the *Sydney Morning Herald* in the 1960s and 1970s, and that doctors referred patients to Chelmsford, does not mean that Mr Cannane's reliance on the Royal Commission finding was unreasonable. Nor does that evidence indicate that the Royal Commission finding was in any way wrong. It was not contrary to evidence and logic for Mr Cannane to rely on the Royal Commission finding.

814 The applicants' submissions then further stretch the bounds of credulity. They refer to Mr Cannane's evidence that:

I felt it was important in establishing the role of Scientologists at Chelmsford to set out some of the background and history of Chelmsford and the ensuing scandal that led to the Royal Commission... I consider that, when writing a story or book, it is important to make clear that there were real human victims of the practice of DST and give some acknowledgment to their suffering...

815 Mr Cannane was right. This was important. But the applicants submitted:

This rationale for setting out the background and history of Chelmsford in the matter complained of presupposed that there were 'victims' of the practice of DST and that they had 'suffered'. Mr Cannane's narrative design dictated that Chelmsford, DST and the applicants were to be presented as a story of 'atrocities and horrors'. He intended to portray the applicants in a highly negative light from the outset because that was the role they were assigned to play in his story.

816 Mr Cannane had the benefit of the Royal Commission report which exposed atrocities and horrors at Chelmsford and the applicants' roles in perpetuating those atrocities and horrors on patients who, on any reasonable view, were the victims of the applicants' gross negligence, unethical conduct and medical malpractice. It was not Mr Cannane's "narrative design" that had this effect. It was the findings of the Royal Commission which had stood unchallenged and undisturbed for decades. Those findings include that the applicants did nothing about the serious dangers of the treatment resulting in an unacceptable number of deaths. Mr Cannane did not need to create a narrative design about the applicants. He merely needed to refer to the Royal Commission's findings about what went on at Chelmsford for the applicants to appear in a highly negative light. The applicants appear to work on the assumption that Mr Cannane was obliged to disregard the Royal Commission and was not entitled to treat it as an authoritative statement of the events at Chelmsford which had stood unchallenged for decades. There is no rational reason why Mr Cannane would have taken the approach the applicants appear to assume was necessary in order for his conduct to be reasonable.

817 It is not correct to say that Mr Cannane agreed that he did not need to name Dr Gill in the Chapter. His evidence as a whole was to the contrary effect. He said:

No, I didn't have to name him except he was one of the four doctors who did deep sleep therapy and he was a significant figure there.

...

I was talking there a kind of about a collective responsibility for the fame – the four main doctors for ignoring the early warning signs and also continuing the practice and to allow that practice to continue. And I thought it was important to name him there because I was aware that he was, effectively, the superintendent of that hospital. And really, to be honest, if I'm talking about that it was probably remiss of me not to name him at that point.

...

I sat down in the state library going through the volumes [of the Royal Commission report] for a week. I then went back. I read a lot. It was really clear to me that Slattery J described him [Dr Gill] as a de facto superintendent of that hospital.

818 Given the context of the Chapter, naming Dr Gill (and Mr Herron, who was Mr Hart's doctor) was necessary and reasonable.

819 The applicants' submissions in respect of Mr Cannane's evidence about the imputations he intended to convey is similarly inaccurate. According to the applicants he admitted he knew at the time he published the matter complained of that he had no proper basis to convey the following imputations of and concerning Mr Herron – A, D, E, G, H, J and M. However, he did no such thing. Properly understood, his evidence was that he had a proper basis for conveying all of the imputations he intended to convey about Mr Herron. The same applies to Dr Gill. The tendentiousness and unreliability of the applicants' submissions as to the effect of Mr Cannane's evidence is exposed by an example identified by the respondents as follows:

For example, in AS [152.2], the Applicants assert that Mr Cannane knew that there was no basis to say that Mr Herron caused Mr Hart to be sedated and given ECT without Mr Hart's consent. The evidence referred to in the footnote establishes only that Mr Cannane agreed that there was no evidence in the *Hart v Herron* proceedings permitting a finding that Herron knew at the time that Mr Hart had not consented. That is an entirely different (and narrower) proposition.

820 As the respondents pointed out, Mr Cannane was a frank and reasonable witness. He accepted:

- (a) That there was not a basis for conveying Imputation G (Herron) and Imputation C (Gill) [referred to as imputation G in these reasons], without further research: T901.39-47;
- (b) That he did not have specific information to the effect that Dr Herron or Dr Gill lied to patients' families or denied families visitation, because the Royal Commission did not identify which individuals were responsible for that: T902.22-903.6 (Imputation H, Herron) and T909.4-16 (Imputation D, Gill)

[referred to as imputation H in these reasons]):

- (c) That he did not attribute responsibility for all 24 deaths at Chelmsford to Mr Herron: T903.15-31 (Imputation J, Herron);
- (d) That he was aware that many of Dr Bailey's patients were given DST without consent and that Mr Hart (a Herron patient) was given DST without consent, but was not aware of other Herron patients being given DST without consent: T905.30-44 (Imputation M, Herron);
- (e) That there was no basis for suggesting that Dr Gill defrauded Health Funds: T815.1-6 (Imputation G, Gill [referred to as imputation L in these reasons]); and
- (f) That he had no knowledge of Dr Gill treating patients without their consent: T909.43-46 (Imputation H, Gill [referred to as imputation M in these reasons]).

821 This evidence is unsurprising because it reflects Mr Cannane's evidence about what he did not intend to convey. As I have found, imputations G, H, J, M, (which cover all of the above imputations with respect to Mr Herron and Dr Gill) were not conveyed.

822 As the respondents submitted:

For the other imputations referred to in AS [152]-[153], Mr Cannane intended to convey the imputations and had a reason to do so, as set out in his evidence. When proper attention is paid to the evidence, it is clear that Mr Cannane did not make the various 'admissions' asserted by the Applicants. There are no imputations where Mr Cannane intended to convey the defamatory meaning without a belief in the truth of those meanings.

823 Accordingly, I accept that there is no example in respect of which Mr Cannane intended to convey an imputation but did not believe in the truth of the imputation.

824 The applicants' submission that the "Court would conclude that Mr Cannane wrote the matter complained of without due regard for what defamatory meanings it would carry about the applicants and what basis he had to support the truth of such meanings" is irreconcilable with Mr Cannane's evidence, considered fairly (rather than tendentiously and selectively as the applicants choose to do). From the whole of his evidence I am satisfied that Mr Cannane exhibited a high level of care and diligence in ensuring that what he conveyed was accurate having regard to his sources, which included two sources he was entitled to consider unimpeachable – the Royal Commission report and the outcome in the *Hart v Herron* proceedings.

825 The applicants' submission that Mr Cannane selectively omitted anything inconsistent with the story of atrocities and horrors he wished to tell cannot withstand scrutiny. At the risk of

repetition, the idea that Mr Cannane would second-guess the findings of the Royal Commission is unrealistic.

826 The applicants complain that Mr Cannane uncritically accepted the Commissioner's description of Chelmsford as "cloaked in secrecy", as alleged at p 179 of the matter complained of that Chelmsford operated "like a secretive cult". The fact that the applicants can point to material showing that some others in the medical profession must have known about DST does not mean the Royal Commission finding (set out above) is inaccurate. Those matters do not make the Royal Commission's finding "obviously untenable". As noted, there is evidence that senior members of the RANZCP did not know about DST until 1979. Dr Bailey had no choice but to give evidence in various coronial inquests and proceedings. Some referring doctors and others must have known the details of DST. The Department of Health did know about the drug regime. But this does not mean that DST was widely known amongst the medical profession. Nor does it mean that the Royal Commission finding that DST at Chelmsford involved "a systematic cloak of secrecy about the treatments, a blanket on the disclosure of information relating to it and a fraudulent cover-up of deaths and other incidents at the hospital" was incorrect. The Royal Commission was a vast enterprise involving a two year investigation. Mr Cannane was entitled to conclude that a finding in these strong terms was sound.

827 The applicants submitted:

Mr Cannane knew at the time of publication that the New South Wales Court of Appeal had held that it was inappropriate to have charged the doctors, and that the High Court had dismissed disciplinary proceedings recommended by the Royal Commissioner. Mr Cannane also knew that Dr Bailey had been charged with manslaughter over the death of Miriam Podio, but that the case was dismissed at committal for lack of evidence, and that Dr Herron was not charged over the death of Audrey Francis, and Dr Gill was not charged over the death of John Adams, also for lack of evidence. Mr Cannane did not refer to any of these matters in the book, despite asserting at page 190 of the matter complained of that 'the Chelmsford doctors continued to avoid accountability for their actions'.

(Footnotes omitted).

828 The applicants' focus on these events as somehow exculpatory of them is untenable. Having criminal and disciplinary proceedings stayed due to the passage of time must have involved a great relief for the applicants, as must have been other decisions which meant that they would not face prosecution in relation to deaths at Chelmsford, but it involves no form of exculpation or vindication of them. The findings of the Royal Commission remained. The respondents also noted the statement in *Gill v Walton* (1991) 25 NSWLR 190 at 202 per Gleeson CJ as follows:

The resolution of the issues that arise in relation to the application for a stay of proceedings in respect of the principal complaints against the claimants involves an unusually difficult task of balancing conflicting interests and considerations; a task that is made even more difficult by the extraordinary history of the matter. The allegations against the claimants are serious and they are supported by the findings of the Royal Commission. On the other hand, the delay in bringing the complaints was both extreme and unjustifiable. The Royal Commission was very critical of the department's performance in that regard. That delay has significantly prejudiced the claimants in relation to their capacity to defend themselves, yet the prejudice is not so extreme that it can be concluded that they cannot now be given a fair hearing. The public has an interest in due enforcement of the standards applicable to medical practitioners, and the Royal Commission has found that there were serious breaches of those standards by the claimants. The first opponent has invoked the statutory procedure established to deal with such breaches. However, this Court held, back in 1986, at a time when it was well aware of the seriousness of the allegations against the practitioners involved, and of the widespread public concern about what had gone on at Chelmsford, that, in the light of the delay in taking action against them, it would be harsh and oppressive to pursue disciplinary proceedings closely related in nature to the proceedings presently in question. The High Court refused special leave to appeal from that decision.

The matter is finely balanced but, in the end, I consider that the decision that was made in *Herron v McGregor* in 1986 is the factor which tips the scales in favour of the claimants. What is involved is not merely consistency of adjudication, although that is significant. More important, it seems to me that it would be oppressive to require the claimants to face new proceedings, some five years after the original proceedings against them were stayed. That consideration, combined with the significant prejudice they have already suffered by reason of the department's unreasonable delay, produces the result that the new proceedings, in so far as they relate to the principal complaints, should also be stayed.

829 The applicants' conduct, so roundly condemned by the Royal Commission, was not vindicated by the stays of the disciplinary and criminal proceedings against them or the fact that they could not be made to face criminal prosecution for their conduct. The stays and other decisions changed nothing about the Royal Commission's findings. The fact that the applicants escaped potential disciplinary and criminal sanctions for their conduct because of the passage of time or the lack of proof to the criminal standard was not some kind of victory for the applicants which Mr Cannane should have reported as such. He was quite right to note that "the Chelmsford doctors continued to avoid accountability for their actions" as this was the practical effect of the stays and other decisions.

830 The applicants complain about inconsistencies in Mr Hart's version of events about which Mr Cannane should have tested Mr Hart. In fact, as Mr Cannane explained about a speech Mr Hart had given:

Look, it's a speech and I don't know what happened with the transmission of the speech and the transcription of the speech and whether that was an accurate portrayal of that. Certainly, I used aspects of this speech to help me with my section, but I was also using other sources as well. So look, I didn't cross-check that particular part of the speech at

the time because I wasn't using that for the publication.

...

...it's something that he said at the time. I didn't choose to use it. I didn't therefore test it. I tested the things that I was planning to use. So – I mean, that's all I can say about that. I don't remember that part of the speech. I didn't use it. It's not in my book.

But the point is you didn't test him?--- No. That's not true. I didn't test him about that paragraph, but it doesn't mean I didn't test him.

...

Sure. You had conversations with him where he told you things and you just accepted them without testing them?---Well, that's not true.

Well, you've given no evidence at all in your affidavit of any testing that you did with him of these allegations?--- No. I haven't. That's true.

And I want to suggest to you you didn't test him. You just listened and put in your book the bits that you ultimately chose to put in?--- I don't agree with that.

And that an investigative journalist reading this speech, which you did read and you did rely on, including putting it in your endnotes, would have been startled to see that quite different account that he's giving in this speech in a public forum?--- I don't agree with that.

831 I accept Mr Cannane's evidence. He consistently appeared as a careful and honest witness who had taken numerous steps to ensure the accuracy of the story he was telling.

832 According to the applicants:

Mr Cannane knew at the time of publication that DST, in some forms, was historically regarded as an acceptable method of treatment, including by the College, and that it was used in New Zealand right into the 1970s. He did not acknowledge this in the matter complained of, instead asserting without qualification at page 178 that 'other psychiatrists had rejected Bailey's theories'. Mr Cannane made no attempt to distinguish between DST as practised by Dr Bailey and the Chelmsford doctors and DST as practised elsewhere in the world.

833 In fact Mr Cannane gave this evidence, which is consistent with the expert evidence in this case:

Now, I want to suggest to you that you understood that upon reading this passage, as far as the college was concerned that historically, deep sleep was an accepted form of practice?--- It depends what you mean by deep sleep because I feel like there was Harry Bailey's version of deep sleep which may have been different to other versions of deep sleep. So when they – when they're referring to deep sleep, and I think, for example, Dr Sargant referred to it as modified narcosis, then it could be a different form of deep sleep so I think it's hard to say that one size fits all of deep sleep. So they may have endorsed or allowed or thought it was okay to have a certain version of that at the time, but I can't be sure that it was the same version that Harry Bailey ran.

834 This evidence supports the submission of the respondents to this effect:

As to the question of DST being used elsewhere (AS [158.4]), the text of the chapter about which the Applicants complain is related specifically to Dr Bailey's treatment at Chelmsford. As Mr Cannane said in his cross-examination, it does not appear that either of the publications to which he was referred dealt with the specifics of DST, as practised at Chelmsford. The most direct evidence available to Mr Cannane about Dr Bailey's version of DST was of the trial at Parramatta, with which Bailey was involved. It was entirely reasonable for Mr Cannane to refer to that material and not to more peripheral matters. The applicants have not explained why Mr Cannane was supposed to embark on a history of sedation therapy, as some sort of justification for the activities of the applicants at Chelmsford, in circumstances where other manifestations of it were quite different.

835 The applicants submitted:

At page 179, Mr Cannane reported as a fact that Barry Hart suffered brain damage as a result of his treatment at Chelmsford, although there was no finding to that effect by the Royal Commission. In making this claim, Mr Cannane relied on Mr Hart's unpublished manuscript, yet he failed to make any reference to the opinion of Dr Snowdon, referred to in that manuscript, that Mr Hart had not suffered any brain damage, and that his symptoms were merely 'a consequence of his own personality'. Mr Cannane ultimately agreed that it was an oversight not to have acknowledged that there was a dispute as to whether Mr Hart was brain damaged, and that it would have been 'much better' if he had acknowledged Dr Snowdon's opinion.

836 Mr Cannane's evidence was that:

Well, Barry Hart told me it had caused him brain damage. Other doctors backed that up. Yes, Dr Snowdon had a different view. As I said, I wasn't really focusing on this section of the book but that's what Barry told me and other doctors like Dr Sydney Smith, for example, backed up Barry's version that he did have what they call an anoxic brain damage.

...

I do know of other – two other doctors who said that Barry Hart did have brain damage so obviously it is contested if Dr Snowdon's views are to be believed.

...

But they're very important words, aren't they; his brain was damaged. You're accusing my client of causing his patient brain damage?---Yes, I am, and I was relying on the views of two doctors who had given evidence in other cases for that verification.

Well, you don't say that you were. You presented it as a fact. That's right, isn't it?---Yes, I do present it as a fact, that's right.

...

So how can you explain, Mr Cannane, that in support of the assertion of fact that you've made in this book that my client caused Mr Hart brain damage, you're content to rely on an unpublished manuscript whereas in that same manuscript you had before you a contrary medical view and you make no reference to it?---Well, look, I accept that I should have made reference to that. I had read other opinions about Barry Hart and his brain damage and I felt like that backed up Barry Hart's assertion but I think that was an oversight of me not to see that and acknowledge that it was contested.



And do you accept now that it was very unfair of you to not put that in. It was very unfair to Dr Herron?---I think – look, I think it would have been much better if I had put that in. There’s a lot of allegations about Barry Hart’s treatment but I think that would have been much better if I had balanced that out or perhaps removed the brain damage quote or at least said it was contested.

837 Mr Cannane’s preparedness to make these concessions gives further support to my conclusion that he was a careful and honest witness whose evidence should be accepted. But in circumstances where Mr Cannane had Mr Hart’s testimony, supported by medical experts, it was by no means an indicator of unreasonableness for him not to refer to Dr Snowden’s contrary views about Mr Hart’s brain damage.

838 The applicants submitted:

There are no examples of Mr Cannane choosing to include evidence which was favourable to the applicants. These examples demonstrate that Mr Cannane was systematically picking a side in his account of Chelmsford, being the side which was most consistent with the ‘*atrocities and horrors*’ narrative he had chosen to tell about Chelmsford.

839 The Royal Commission report effectively fixed the narrative of “atrocities and horrors” that could be told about Chelmsford. In so doing, the applicants had also been thoroughly discredited by the Royal Commission findings. And as the respondents submitted:

The Applicants also suggest (AS [159]) that Mr Cannane chose not to refer in his book to any evidence which was favourable to the Applicants. The question is where such evidence might be located. No expert willing to defend DST was referred to in the Royal Commission Report. None is available now. Mr Cannane’s job was to assess the facts available to him in a reasonable way. That he did, including by reference to the Royal Commission Report.

840 The applicants submitted that:

Mr Cannane became aware during the writing of the matter complained of that both Dr Herron and Dr Gill were still alive, and he knew that they strongly contested the version of events given by former patients at the Royal Commission, yet he did not approach either of them for comment before publication.

841 This is correct. Contrary to the applicants’ submissions, however, Mr Cannane’s three reasons for so conducting himself were rational and compelling. First, the Book is about Scientology not Chelmsford. Second, Mr Cannane was right to conclude that the Royal Commission’s findings were “by far the best available source for information about Chelmsford”. Third, Mr Cannane’s lack of confidence as to the truthfulness of the applicants about Chelmsford was a sound judgment based on the Royal Commission findings. This case is not analogous to other cases. The circumstances of a two year Royal Commission culminating in a multi-volume report which has stood unchallenged for decades (which had made findings of dishonesty

against the applicants about the very subject matter involved in the strongest possible terms), as well as the outcome in *Hart v Herron* where Mr Hart succeeded in his claims of false imprisonment and assault and battery, take this case far outside of the ordinary course. Mr Cannane was entitled to treat these sources of information as authoritative and unimpeachable.

842 Further, as the respondents submitted, the comparison the applicants seek to make between Mr Cannane's treatment of the applicants and others involve false analogies. The respondents said this, with which I agree:

- (a) In respect of the lawyers [Sackar J, Patrick Griffin SC and Harold Sperling QC], none of those individuals had given evidence during the Royal Commission. None had been found to be liars. Each of them may have had something to contribute to Mr Cannane in respect of the focus of his research: the role of Rosa Nicholson and Scientology; and
- (b) In respect of Ms Eastgate, Mr Cannane approached Ms Eastgate because he did not have conclusive evidence, just allegations (878.21-28). That was not the case in respect of the Applicants, where Mr Cannane had the benefit of the Royal Commission findings.

843 Accordingly, I reject the applicants' submission that:

When it suited his purposes, however, he was prepared to question the Royal Commission's assessment of certain witnesses. For example, Mr Cannane considered it 'obvious' that Rosa Nicholson gave dishonest evidence, characterising the Royal Commissioner's findings about her as 'generous'. Mr Cannane was also prepared to seek comment from obviously untrustworthy people such as Jan Eastgate, whom he suspected of coaching witnesses. In light of this, his decision not to seek comment from the applicants cannot reasonably be explained on the basis of any reservations Mr Cannane might have held about their honesty.

844 Mr Cannane's view about the applicants' lack of honesty about matters relating to Chelmsford was a sound and reasonable basis for his decision not to contact the applicants.

845 The applicants submitted that:

In any event, such an approach is quite inconsistent with the notion of reasonable conduct in publishing. It is not for a publisher to form an a priori view of a person's credibility (including based on some other person's assessment of that credibility), and use that as a reason not to extend the opportunity to respond to the allegations in question, prior to publication. Where a publisher seeks, obtains and publishes a response to allegations to be made, the publisher is not obliged to endorse the response. It is responsible journalistic practice to seek and publish a fair summary of such response, either without comment or (if done responsibly) pointing to any difficulties raised by the response, or to remove or modify the allegations in light of the response. By failing to engage in that process at all in relation to the applicants, Mr Cannane was acting unreasonably.

846 I find this submission entirely unrealistic given the circumstances of the Royal Commission report and its findings about the applicants concerning the very subject matter of the Chapter.

The applicants had a two year investigation to put forward their version of events. They gave evidence over days and days. Their version of events was rejected in the strongest possible terms. The applicants called no expert evidence before the Royal Commission in an attempt to vindicate their conduct. They relied on their own evidence which was found to be dishonest. In these circumstances, the idea that Mr Cannane was obliged to give the applicants another opportunity to present their dishonest and self-serving version of events, which had been so comprehensively rejected in the Royal Commission report, is untenable. Consistent with the reasoning in *Lange* at 574 this was a rare case in which it was simply unnecessary to give the applicants any further opportunity to attempt to rewrite history.

847 For the same reasons, the applicants' reliance on defeasance of qualified privilege by Mr Cannane being actuated by malice must fail. There is no evidence which comes close to establishing that Mr Cannane was actuated by malice. He had no improper motive in doing what he did. He wished to contribute to the store of knowledge about the social and medical history of New South Wales and did so with care, diligence, honesty and in a reasonable manner.

848 The conduct of the defendants in publishing the defamatory matter was reasonable in the circumstances. The defence of qualified privilege under s 30 of the Act has been established. It operates in relation to both Mr Cannane and HarperCollins for the reasons already given.

## 11. CONTEXTUAL TRUTH

849 Section 26 of the Act provides that:

It is a defence to the publication of defamatory matter if the defendant proves that -

- (a) the matter carried, in addition to the defamatory imputations of which the plaintiff complains, one or more other imputations ('**contextual imputations**') that are substantially true, and
- (b) the defamatory imputations do not further harm the reputation of the plaintiff because of the substantial truth of the contextual imputations.

### 11.1 Mr Herron

850 The respondents rely on two contextual implications:

- (a) That the Applicant as a psychiatrist practising at Chelmsford Hospital engaged in gross negligence and callous treatment of his patients; and
- (b) That the Applicant is unfit to practice medicine as a doctor.

851 According to the respondents, the evidence on which they relied to prove the truth of the applicants' alleged imputations proved also that Mr Herron engaged in gross negligence and callous treatment of his patients. As to the second contextual imputation, they said:

In 1997 Mr Herron was removed from the board of medical practitioners. The Medical Tribunal found that because of Mr Herron's conduct in respect of two particular patients and because there was no indication that Mr Herron would change his conduct, the 'only appropriate protective order' in the circumstances of the case was to remove Mr Herron's name from the register of medical practitioners: OTH00056.9-10 (RTB15).

852 The respondents submitted that:

The 'sting' of the imputations pleaded by the Applicants is removed by the contextual imputations. The pleaded imputations relate (in one way or another) to Mr Herron's skill, competence and integrity as a psychiatrist. The fact that Mr Herron did the things particularised, and that the Medical Tribunal has removed Mr Herron's name from the list of practitioners demonstrates that he is not someone with the skill, competence and integrity to be entrusted with the heavy responsibilities of a medical practitioner. In light of those matters, the imputations pleaded by the Applicants do not harm that reputation of Mr Herron.

853 As to the first contextual imputation, I agree with the applicants that it is not conveyed in addition to the imputations of which Mr Herron complains, specifically imputations A-F, H-K, M and N. As the applicants put it:

With its twin stings of (a) gross negligence and (b) callous treatment of patients, the contextual imputation is only a rolled-up reformulation of a number of Dr Herron's imputations.

The sting that Dr Herron was grossly negligent is obviously justifiable on the same evidence as Imputations A, C, E, F, I and J, and for that reason, does not differ in substance from those imputations.

The relevant definition of 'callous' is 'Hardened, unfeeling, insensible' (Oxford English Dictionary, 2nd ed, vol. 2 page 793). To impute that Dr Herron treated his patients callously is to impute that he treated them harshly, uncaringly, and in disregard of their rights and best interests. Such a sting is justifiable on the same evidence as (for example) Imputations B, D, H, K and M, and for that reason, does not differ in substance from those imputations.

854 As to the second contextual imputation, the applicants submitted that:

This contextual imputation is not reasonably conveyed by the matter complained of, because the matter does not allege in terms that Dr Herron was unfit to practice medicine. That may be the ultimate conclusion some readers would independently have drawn, but it is not implicit in the matter itself. There is a distinction between what the ordinary reasonable reader could reasonably understand from what the respondents have actually said in the matter complained of, and the conclusions they might reach by taking into account their own beliefs and prejudices. 'Inferences upon an inference' cannot in law form the basis of an actionable imputation or contextual imputation: *Amalgamated Television Services Pty Ltd v Marsden* (1998) 43 NSWLR

158 at 166-167 per Hunt CJ at CL. In this case, the proposition that Dr Herron fell short of the standards of professional competence and propriety expected of a psychiatrist is an inference which may arise directly from the matter, but the proposition that he was on that account unfit to practice medicine is an inference built upon that direct inference, and is not proper material for a contextual imputation.

855 I accept this submission.

856 The applicants also submitted that the second contextual implication does not differ in substance from Mr Herron's pleaded imputations. The respondents rely on the same material for the contextual imputation as they do to prove the truth of Mr Herron's pleaded imputations.

857 I do not accept that the defamatory matter carried in addition to the pleaded imputations the further imputations on which the respondents relied. There are simply not one or more "other" imputations which are conveyed having regard to the pleaded imputations.

## **11.2 Dr Gill**

858 Contextual imputation I with respect to Dr Gill is that the applicant as a psychiatrist practising at Chelmsford engaged in gross negligence and callous treatment of his patients. For the same reasons as set out above with respect to Mr Herron this imputation is not conveyed in addition to the pleaded imputations of Dr Gill.

859 Contextual imputations II-IX are the same as Dr Gill's pleaded imputations with the word "psychiatrist" replaced by "doctor". The applicants submitted that there is no difference in substance between the two sets of imputations. They noted that the evidence which would justify both sets of imputations is exactly the same, as is demonstrated by the respondents' particulars of justification. So much may be accepted. But it must also be accepted that this is an unusual case. Insofar as the Chapter conveys the imputation about Dr Gill it does so by identifying him as a doctor. If there is any material difference between Dr Gill being a psychiatrist and being a doctor (which I do not consider there is – see above), it is necessarily the case that the contextual implications are in addition to the pleaded imputations and are substantially true and the defamatory imputations do not further harm the reputation of the applicant because of the substantial truth of the contextual imputations.

## **12. FAIR REPORT/FAIR SUMMARY**

### **12.1 Principles**

860 Section 29(1) of the Act provides that:

It is a defence to the publication of defamatory matter if the defendant proves that the

matter was, or was contained in, a fair report of any proceedings of public concern.

861 Section 29(4) defines “proceedings of public concern” as including “any proceedings in public of a court or arbitral tribunal of any country” and “any proceedings in public of an inquiry held under the law of any country or under the authority of the government of any country”. The Royal Commission report is clearly a “proceeding of public concern”. The issue is whether the Chapter is a fair report of these proceedings of public concern.

862 Section 28(1)(b) of the Act provides that it is a defence to the publication of defamatory matter if the defendant proves that the matter was contained in a fair summary of, or a fair extract from, a public document. The definition of “public document” in s 28(4) encompasses the report of the Royal Commission.

863 The respondents referred to *Thom v Associated Newspapers Ltd* (1964) 64 SR (NSW) 376 at 380 that:

The report need not be verbatim, but to be privileged it must accurately express what took place. Errors may occur; but if they are such as not substantially to alter the impression that the reader would have received had he been present at the trial, the protection is not lost.

864 They referred also to *Waterhouse v Broadcasting Station 2GB Pty Ltd* (1985) 1 NSWLR 58 (2GB) at 63:

A fair report is a substantially accurate summary of the proceedings, neither more nor less. The question is not whether it is fair or unfair to any particular person; the question is whether it substantially records what was said and done.

865 Further, they referred to *Chakravarti v Advertiser Newspapers Ltd* [1998] HCA 37; (1998) 193 CLR 519 at [42] that:

It is well settled that to be fair and accurate, a report need not be a complete report of the proceedings in question. Nor need it be accurate in every respect. It must, however, be substantially accurate. And the question whether it is substantially accurate is a question of fact...

866 In *Cook v Alexander* [1974] 1 QB 279 at 288 Lord Denning MR said:

In these days the debates in Parliament take so long that no newspaper could possibly report the debates in full, nor give the names of all the speakers, nor even summarise the main speeches. When a debate covers a particular subject matter, there are often some aspects which are of greater public interest than others. If the reporter is to give the public any impression at all of the proceedings, he must be allowed to be selective and to cover those matters only which appear to be of particular public interest. Even then, he need not report it verbatim in word for word or letter by letter. It is sufficient if it is a fair presentation of what took place so as to convey to the reader the impression which the debate itself would have made on a hearer of it.

867 In *Feldman v Nationwide News Pty Ltd* [2020] NSWSC 26 at [212] Campbell J said:

In *Cook v Alexander* [1974] 1 QB 279 Lord Denning MR rejected the proposition that for a report of Parliament to be fair and accurate, there needed to be a precis of the whole proceedings or debate.

868 Other decisions also confirm that a report may relate to part only of a proceeding: *Sands v Channel Seven Adelaide Pty Ltd & Anor* [2010] SASC 202 at [135]-[142], *Nationwide News Pty Ltd v Moodie* [2003] WASCA 273; (2003) 28 WAR 314 at [75]-[79]; *2GB* at 62-63.

869 The respondents accepted that a report is required to indicate, expressly or impliedly, that it is a report of the proceedings. In *Rogers v Nationwide News Pty Ltd* [2003] HCA 52; (2003) 216 CLR 327 at [18] Gleeson CJ said:

Matter does not constitute a report of proceedings merely because it repeats information obtained from those proceedings. To take an example from *Grech v Odhams Press Ltd* [[1958] 2 QB 275 at 285], if a statement made by a witness in a proceeding is fairly and accurately reported, and attributed to the witness who made it, then the protection may be attracted; it would be otherwise if, without attribution to the witness or the proceedings, the substance of the statement were merely repeated. The importance of attribution, and the making of what purports to be a report of proceedings, as distinct from the mere repetition of information that emerges in the course of proceedings, is illustrated by *Burchett v Kane* [[1980] 2 NSWLR 266.]. The requirement of attribution does not necessarily require direct quotation and acknowledgment; but it must appear that the published matter bears the character of a report of the proceedings in question. It is not enough that the proceedings are a source of information, or the subject of an expression of opinion.

870 The applicants referred to *Burchett v Kane* [1980] 2 NSWLR 266 at 273 to the effect that a report is “factual recounting of an event or situation”, “essentially descriptive of an event or series of events” and “limited to an account of events which have happened”, and does not include the independent comments or opinions of the reporter.

871 They referred also to the judgment of Mason P in *Nationwide News Pty Ltd v Rogers* [2002] NSWCA 71 at [10]:

The essential point is that a requirement of attribution places the onus on the reporter to differentiate between the event reported (here court proceedings) upon which the reporter’s privilege is derivative, on the one hand; and background information, statements of fact or the reporter’s own commentary, on the other hand. The reader is thus enabled to assess and weigh the information by recognising its various sources. Since, *ex hypothesi* one is dealing with defamatory material it is not unreasonable to require such discrimination.

872 The applicants referred to *Macquarie Radio Network Pty Ltd v Dent* [2007] NSWCA 261 at [72] that:

In circumstances where a later publication adds, in a significant way and without

sufficient differentiation, to the material that is contained in the protected report, it is not sufficient for there to be a mix of material, some of which accurately and fairly summarises what is in the ‘protected report’ and some of which does not.

873 The applicants submitted that similar considerations must apply to the fair summary defence in s 28. That is, the matter must bear the character of a summary of a public document. Accordingly:

This means that (a) there must be attribution to the relevant public document, and it is not sufficient that the document is merely a source of information; and (b) the admixture of substantial extraneous material without sufficient differentiation from the information derived from the relevant public document deprives the matter as a whole of the quality of a fair summary.

## 12.2 Competing submissions

874 The respondents submitted that the matter complained of heavily references the evidence given in the Royal Commission and the Royal Commission report both in end notes and in the text of the Chapter. The ordinary reasonable reader will read the entirety of the matter including the end notes with greater care and attention than the reader of a newspaper. According to the respondents:

Having regard to the numerous footnotes that link to evidence and findings of the Royal Commission, the ordinary reasonable reader would conclude that insofar as the chapter dealt with the matters the subject of the Royal Commission, what was being reported in the chapter was a summary of the Royal Commission report and proceedings.

875 The respondents noted that after describing Mr Hart’s treatment the Chapter proceeds to the key pp 179-180 describing Chelmsford and all but one of the end notes is to the Royal Commission report. The story of the mounting death toll is plainly based on findings in the Royal Commission report that 24 people died which is noted at p 177 and p 192. This is confirmed by the statement on p 192 that:

While the report exposed the truth about deep sleep therapy and how it was practised at Chelmsford it never quite got to the bottom of the role the Church of Scientology played in exposing it.

876 The ordinary reasonable reader would understand that “truth” to be the material on pp 178-179 about the practice of DST at Chelmsford.

877 As such, the respondents submitted that:

For those reasons, the ordinary reasonable reader would have understood the chapter to be, in all relevant respects, a report of the evidence given to the Royal Commission and a summary of the Report itself. The next question is, then, whether it is a fair and accurate summary of the relevant sections of the Report.



878 The respondents submitted that each of the statements in the Chapter is supported by the findings of the Royal Commission.

879 As to the deaths at Chelmsford, footnote 11 is to Vol 4 p 26 of the Royal Commission report which stated:

The outstanding feature of the series of DST deaths is the preponderance of youthful people. Eleven of the 24 deaths were under the age of 40, and 16 were under the age of 50. The mean age at death was 42.3, with a median age of about 45 years. This is grossly abnormal by comparison with the general mortality data in Australia.

880 On the preceding page, the Royal Commission report said:

The Royal Commission has concluded that there were at least 24 deaths caused by DST.

881 The respondents noted that:

Other material in the Report containing details of the number of deaths and the types of death which arose are addressed at Vol 1, pp50, 175-176 (OTH0008) and Vol 4, pp25-26, 29-30 (OTH0006). Each of the deaths referred to by the Royal Commission was the subject of an individual chapter in Volume 4 (OTH0006).

882 The respondents submitted that other key examples involved a summary of the Royal Commission's findings, including:

- (a) The treatment of Barry Hart and his physical condition after treatment at Chelmsford is addressed at Vol 3, p111-112 and 228: OTH00009 (RTB11);
- (b) The secretive nature of Chelmsford, including the lack of communication with families is addressed at Vol 1, p58, pp169-174: OTH00008 (RTB10);
- (c) The position of the nurses at Chelmsford is addressed at Vol 1, pp51, 128, 163, 168; Vol 2, p29; Vol 3, p112: OTH00008 (RTB10), OTH00014 (12) and OTH00009 (RTB11);
- (d) The question of falsified death certificates is addressed at Vol 1, p51; Vol 4, p11: OTH00008 (RTB10) and OTH00006 (RTB10);
- (e) The question of fraudulent claims on health funds is addressed at Vol 6, p210, p212: OTH00010 (RTB11).

883 The applicants submitted that the Chapter commences with the story of Mr Hart which was not sourced to the Royal Commission findings. The Chapter then moves on to Chelmsford before returning again to Mr Hart. The applicants noted:

Out of the 17 full paragraphs in pages 176-179 of the book, 14 are based on sources other than the Royal Commission transcript, evidence or report. Of the endnotes for this section, 11 out of 18 cite sources other than the Royal Commission transcript, evidence or report.

884 Pages 180-192 concern how Chelmsford came to the attention of the public and to the ultimate establishment of the Royal Commission. The applicants noted:

This part of the chapter includes only six endnotes citing the Royal Commission report, only 22 endnotes citing transcript or statements from the Royal Commission, and 52 endnotes from other sources.

885 The applicants submitted:

Of the remaining 62 endnotes to the chapter, only five cite the Royal Commission report and only nine cite Royal Commission evidence. The Royal Commission itself is first mentioned in the body of the chapter on page 192.

886 The Chapter then discusses the evidence given by Ms Nicholson at the Royal Commission.

887 The applicants submitted:

Most of the chapter was based on information derived from independent sources. For example, the material about Barry Hart is based on information sourced from Mr Hart himself, including his own unpublished manuscript, his interviews with the second respondent, his 60 minutes interview and a speech he gave. Significant portions of the chapter were also based on an unpublished manuscript by Susan Geason. The second respondent wrote significant parts of the chapter based on interviews he conducted with Barry Hart, Marcia Fawdry, Ron Segal, Margaret Como, Peter Marsh, a relative of Rosa Nicholson, Pat Griffin, and Anthony McClellan.

888 The applicants described the Chapter as involving a qualitatively and quantitatively significant admixture of material from various sources, noting that 18 of 160 citations are to the Royal Commission report and 31 of 160 citations are transcript or evidence from the Royal Commission.

889 The applicants noted that with the exception of p 192 (quoted above), no factual claims are attributed to the Royal Commission transcript, evidence or report within the body of the Chapter. As they put it:

Instead, all of the information, from whichever source it was derived, is woven into the text in the same literary style. The lack of attribution within the body of the text means that there is no linguistic or stylistic differentiation between material derived from other sources, the material derived from the Royal Commission report, or the material derived from the Royal Commission proceedings.

890 The applicants submitted that the fundamental issue is that the matter complained of does not purport to be a report of the Royal Commission's proceedings or a summary of its final report. Rather, it is an historical narrative of the Church of Scientology's involvement in bringing practices at Chelmsford to public attention. The matter complained of is thus primarily about what happened in the background of the Royal Commission. It is not concerned with what

happened at the Royal Commission (s 29) or what the Commissioner found in his final report (s 28).

891 The applicants noted that while it may be accepted that a publication may be expressed in such a way as to make clear that it is a report, including in summary, of only part of proceedings or of a public document, this provides no assistance to the respondents in the present case. As they put it:

That does not remove the need for the publication to be characterised, objectively, *as a report*. Where it is, by reason of its subject-matter, not able to be so characterised, it matters not that it contains references to proceedings or a published document, especially where those are intermixed with other material.

### 12.3 Discussion

892 I agree with the applicants' submissions.

893 The Chapter does not purport to be a report or summary of the Royal Commission proceedings or report. The fact that the Royal Commission report is one of the major sources of the Chapter does not transform the Chapter into something which it does not purport to be. The Chapter is not reporting on or summarising the Royal Commission report. It is telling a story about the hitherto unknown role played by the Church of Scientology in exposing Chelmsford and ensuring that it was the subject of investigation which ultimately culminated in the Royal Commission. In telling that story it was necessary to explain why Chelmsford needed exposure and, in that regard, Mr Cannane used the Royal Commission report as one of a number of sources (albeit clearly a principal source) to describe DST at Chelmsford.

894 As the applicants submitted, the Chapter is an admixture from various sources, but particularly the Royal Commission, all conveyed in the same literary style. The ordinary reasonable reader would not understand that they were reading a report or summary of the Royal Commission report. The fact, which I accept, that they would read the Chapter including the end notes with some care would not have the effect of conveying that they were reading a report of the evidence given to the Royal Commission and a summary of the report itself. Nothing in the text of the Chapter would suggest this to the mind of the ordinary reasonable reader. The Chapter simply does not bear the character of a report or a summary of the Royal Commission evidence or report.

895 In this regard, it is particularly relevant that there is no distinction in style between parts of the Chapter which are sourced to the Royal Commission report and those which have different

sources. The Chapter starts with Mr Hart’s story which is not sourced to the Royal Commission. It interweaves in that story facts which are sourced to the Royal Commission report but there is no distinction in style between the different components. The facts do not purport to be a summary of the Royal Commission report. They are used as part of the story that is being told about Mr Hart. The same interweaving of the story that is being told with findings from the Royal Commission continues throughout the Chapter. None of the findings of the Royal Commission are presented as such. They are presented as facts – reflecting that what is being done is the telling of a story which happens to use the Royal Commission report as a major source.

896 There is a difference between using a public document or public proceeding as a source along with multiple other sources for the purpose of telling a story and providing a report or summary of a public document or public proceeding. The Chapter is an example of the former, not of the latter.

897 For these reasons the defence under ss 28 and 29 must fail. This said, however, I do not accept that the use made by Mr Cannane of the Royal Commission report was unfair. I also do not accept the applicants’ contention that the defamatory matter was not published honestly for the information of the public or the advancement of education. The applicants relied on their submissions with respect to s 30 to support this contention but for the reasons already given I do not accept the applicants’ submissions about s 30.

### 13. DAMAGES

898 For the reasons given above the applicants’ claims must be dismissed. If I am incorrect in these conclusions then the reputation of the applicants would be a matter relevant to the assessment of damages.

899 As the respondents noted:

- (1) the evidence of bad character must relate to the “sector” of the applicant’s reputation with which the imputations relied upon by the applicant were concerned: *Chau Chak Wing* at [94], *Australian Broadcasting Corporation v McBride* [2001] NSWCA 322; (2001) 53 NSWLR 430 at [16]-[23], and *Channel Seven Sydney Pty Ltd v Mahommed* [2010] NSWCA 335; (2010) 278 ALR 232 (***Mahommed***) at [162];

- (2) the evidence can encompass publicity in respect of matters of sufficient notoriety: *Singleton v John Fairfax & Sons Ltd (No 1)* [1983] 2 NSWLR 722 (***Singleton***) at 724 as follows:

There can, in my view, be no doubt that a person's reputation could be tarnished by a particular fact which is of sufficient notoriety. A recent example would perhaps be the report of the Royal Commission conducted a short time ago by the Chief Justice and the publicity which was accorded to the report, which together must surely have detrimentally affected the reputation of the former Chief Stipendiary Magistrate, Mr Farquhar, in a settled and not merely a transitory way so as to show that his reputation in the relevant sector was a bad one. If that is the sort of evidence that Lord Radcliffe had in mind, I would not deny its admissibility upon the issue of reputation...;

and

- (3) a defendant can rely in mitigation on evidence which is properly before the court such as evidence directed to the defence of justification: *Pamplin v Express Newspapers Ltd* [1988] 1 WLR 116 (CA) at 120A-E, *Chau Chak Wing* at [92], *Holt v TCN Channel Nine Pty Ltd* [2014] NSWCA 90; (2014) 86 NSWLR 96 at [26], and *Zunter* at [50].

900 The applicants contended that the respondents had not pleaded reliance on the Royal Commission report as relevant to reputation. As the respondents submitted, however:

In both defences, the Respondents rely, in respect of mitigation of damages, upon ... 'the Applicant's bad reputation amongst colleagues and the community' ([9(c)] of each Defence) and the 'facts matters and circumstances proven by the Respondents in evidence in support of the truth, contextual truth, honest opinion and qualified privilege defences' ([9(b)] of each Defence). One of those matters, relevant to the qualified privilege defence, is the publication of the Royal Commission Report. It was obvious from that pleading that the publication of the Royal Commission Report was a matter upon which the Respondents would rely.

The hearing was conducted on that basis. That can be seen from the exchange at T53.9-54.29 when Senior Counsel for the Applicants first objected to questions being asked of Dr Gill about the Royal Commission Report. Those questions were allowed, including because they were relevant to reputation.

901 The applicants contended that the Royal Commission report was not admissible as evidence of the applicants' reputation and the only authority on which the respondents relied, *Singleton* at 724, should not be applied as it was mere obiter dicta, made in the course of an ex tempore decision, is expressed tentatively, and is confined to a recent report. As the respondents submitted, however:

In circumstances where the events at Chelmsford are recognised by the Chief Justice of the Supreme Court (*DPP v Gill* [1993] NSWCA 84; Ex 3, pg. 1) and the High Court of Australia (*Walton v Gardiner* (1993) 177 CLR 378 at 382) as 'notorious' for many years, that clearly affects the reputation of the Applicants.

902 Further, in *Mahommed* the NSW Court of Appeal held that the principle established in *Goody v Odhams Press Ltd* [1967] 1 QB 333 at 340-341 per Lord Denning MR, that criminal convictions could be taken into account as affecting reputation, extended to findings in civil proceedings (and included findings that occurred after the date of the defamation). At [254] in *Mahommed* this was said:

In my view, such findings, if relevant in the senses already discussed, should be admissible. Save as to the standard of proof, they appear otherwise to stand on much the same footing as convictions: they took place in open court and can be regarded, accordingly, as matters of public knowledge. The tribunal of fact should not be kept in the dark about the plaintiff's reputation at the time it comes to consider the award of damages.

903 I am not persuaded by the applicants' submissions that the Royal Commission report is inadmissible in relation to the applicants' reputation. The report has stood unchallenged for decades. It is a notorious part of the social history of New South Wales. I consider it admissible for the purpose of assessing the applicants' reputation. The same conclusion applies to the findings of the Medical Tribunal in *Tweedale v Herron*. As the respondents said:

The Medical Tribunal as then constituted may not have been a court, but it had judicial members and the power to deregister medical practitioners. The applicants at AS [191] say that 'there is no reason to presume that a decision of the medical Tribunal would be a matter of general public knowledge in the same way as a criminal conviction or judicial findings in a civil matter'; their footnoted authority for that proposition is the affidavit of Richelle Herron. The assertion is, with respect, unconvincing. The evidence of Mr Herron was that the finding was widely known in medical circles (T365.9-10).

904 I also accept the respondents' submissions as follows:

At AS [194]-[196], the Applicants suggest that the reputation they have come to Court to protect is their reputation as 'family men and members of their local communities', and not as medical professionals. That is not how the imputations are pleaded. Each of the imputations is directed to the Applicants as psychiatrists or, in the case of the contextual imputation in respect of Dr Gill, as a doctor.

It is readily apparent why the imputations were pleaded that way: Chapter 14 dealt with Mr Herron and Dr Gill in their roles as medical practitioners at Chelmsford. It makes no comment about their behaviour or character other than as medical practitioners. The defamatory imputations, if they arise, are directed only to matters concerning the Applicants' activities as medical professionals.

In *O'Hagan v Nationwide News Pty Ltd* (2001) 53 NSWLR 89, Meagher JA provides the following example, in considering the evidence that might be relevant to reputation:

[T]he evidence must relate to 'the relevant sector' of the plaintiff's reputation. Thus if a plaintiff sues on a libel that he is a dishonest solicitor, it is not to the point that he has a reputation as a good golfer.

A similar analogy applies here. The Applicants have sued upon various imputations

relating to their capacity as medical practitioners. Their reputations as ‘family men and members of their local communities’ have nothing to do with it (and appear nowhere in the pleadings).

905 Given the narrowness of the relevant sector of the applicants’ reputation and the notoriety of Chelmsford in that sector, I do not accept that the findings of the Royal Commission or Medical Tribunal are too old to be relevant to the applicants’ reputation. As the respondents submitted, the Royal Commission’s findings about Mr Herron and Dr Gill as medical practitioners were devastating.

906 As to Mr Herron, the Royal Commission report said:

- (1) “[o]ne would have expected hindsight to elicit from Mr Herron a strong criticism of barbiturate as a sedative agent and probably some recognition that something had gone terribly wrong. His evidence was singularly free of compassion for those who had died or had been damaged. He treated the whole series of deaths and complications during DST as routine and quite acceptable”: OTH0014.91 (RTB 12); and
- (2) “[i]t may be that part of his personality may involve a genuine subconscious denial but I cannot accept that is the totality of his position. I think there are large parts where he has deliberately concealed the truth. Indeed in the 29 days of his evidence, he only provided factual information in situations where it was clear the information would be available from other sources. Further when he provided that information, he provided it in a manner which concealed the truth. There were times where his answers became almost incomprehensible. Illustrations of this are set out earlier.

Dr Herron engaged in verbal gymnastics with counsel, playing on words, answering the strict letter of the question rather than what was clearly the spirit, in circumstances where it was misleading. He later admitted that he deliberately took this approach to his evidence. He was manipulative both as a witness and as a person. On many occasions he attempted to draw sympathy to his position by expressions of pathos which I have grave doubts he felt. My impression is that he embarked on a deliberate campaign to conceal as much as he could from the Royal Commission while at the same time attempting to paint a picture of a pathetic and wronged man. He was not so”: OTH0014.101 (RTB12).

907 As to Dr Gill, the Royal Commission report said:

- (1) “Dr Gill was the person who took charge of the campaign against any person who criticised Chelmsford which he saw as his hospital. He carried out campaigns against the nurses, against outsiders, in particular the Scientologists and Health. He had a misguided attitude to confidentiality of documents. If he had been honestly concerned about patients’ welfare, he would have been prepared to discuss the problems at Chelmsford and the records with officers of Health. He took a deliberately obstructive approach to the matter and relied on technical legal rights to defend his position. It is clear to me he believed he and the hospital were vulnerable to attack for wrongdoings which occurred there. I do not believe that he fought these campaigns purely as a matter of principle. I believe that he knew that wrongdoing had occurred and he used every device that he could to keep the matters concealed.

He bullied officers from Health. He was uncontrolled and lost his temper with those officers and also with nurses. He was so convinced of his self-righteousness that at times in the witness box, no facts, no matter how glaringly obvious, could change his beliefs. There were times when his contact with reality in my view was quite tenuous.

...

Dr Gill must bear a large part of the responsibility for the consequences of Chelmsford both in terms of the suffering and sometimes deaths of patients, not merely his own, and in terms of the expense to the people of NSW.

He has contributed to the establishment of this Royal Commission because of his obstructive approach to any inquiry or investigation. His attitude and intransigence has cost society dearly”: OTH0014.131-132 (RTB12);

- (2) “[i]n brief, Dr Gill considered his understanding of DST with its cocktail of drugs was adequate to continue with the treatment of John Adams. I do not agree. Without any adequate, professional knowledge of the mode of treatment, its drug regime, its possible complications and risks, Dr Gill relied on the knowledge and experience of Dr Bailey and Dr Herron, followed on behind them, used their regime and subjected his patient, John Adams, to its well documented and serious dangers. Criticism of him is far from ‘misconceived’. He failed to ensure there was close and adequate monitoring of John Adams’ levels of consciousness and of all the other patients who received DST at Chelmsford. He failed to provide sufficient and adequate medical care and supervision for John Adams. There is overwhelming evidence linking and identifying DST as John



Adams' primary cause of death and of many other DST patients at Chelmsford": OTH0006.231 (RTB10); and

- (3) "[i]n summary, Dr Gill was a most unsatisfactory witness. He was prepared to lie when the occasion demanded. He ultimately continued his delusional attacks on innocent people in the witness box in the face of clear evidence that he was wrong. He prepared to involve himself in the falsification or removal of records if his interests were threatened. He showed not the slightest remorse or compassion regarding the deaths of Miriam Podio or John Adams and rejected all criticisms of his role in their management in the face of overwhelming expert opinion of his culpability": OTH0014.129 (RTB12).

908 The applicants agreed that the findings of the Royal Commission were widely publicised. As the respondents said:

Mr Herron agreed that the findings had a devastating effect on him and the reputation witnesses in respect of Mr Herron agreed. Dr Gill was unwilling to accept that the findings had a devastating effect, but the reputation witnesses said that they did.

909 This is consistent with Professor McGorry's evidence about the notoriety amongst medical circles of the events at Chelmsford. I accept the respondents' submission as follows in that regard:

In his cross-examination, Professor McGorry agreed that there were some in the psychiatric community who may now be young enough that they do not automatically associate Dr Gill with Chelmsford and what occurred there (McGorry XXN at T1488.10-12). However, it is also apparent from Professor McGorry's evidence that such a person would 'very rapidly' become aware of the link, on enquiry (McGorry XXN at T1488.4-8). The fact that there may be a small number of psychiatrists who do not make the link does not diminish Professor McGorry's evidence about the psychiatric community as a whole.

910 The evidence about Mr Herron also included the following as identified by the respondents:

- (1) the *Hart v Herron* trial (in which he was found guilty of assault, battery and false imprisonment) had a devastating effect on his professional and domestic life, such that his practice as a psychiatrist had dwindled;
- (2) in December 1986 (during the course of disciplinary proceedings), Mr Herron gave evidence that there was a tendency for no or very few patients to be referred to him when he is on call, for patients to refuse to be referred to him, for GPs not to refer patients to him and for medical practitioners to avoid contact with him at professional gatherings;

- (3) in 1997, Mr Herron was found to be a person who was not fit to be a medical practitioner for matters which were not related to Chelmsford. Mr Herron agreed that this was widely known in medical circles but suggested that it was not widely accepted. The latter involves mere supposition which I do not accept; and
- (4) the impacts from the Royal Commission had continued because Mr Herron was reminded of it by social contacts.

911 If it had been necessary to do so, in these circumstances, I would have accepted the respondents' submission that in the relevant sector of his reputation, as a medical practitioner, Mr Herron has no residual reputation to be protected.

912 In respect of Dr Gill, Mr Wilkinson gave evidence that:

- (1) he knew of no doctor apart from Dr Gill who thought that the medical treatments carried on at Chelmsford were other than discredited and dangerous;
- (2) he knew the Royal Commission had made seriously critical findings about Dr Gill;
- (3) in the psychiatric community and the medical community generally it was notorious that the practice of DST at Chelmsford, including by Dr Gill, involved the mistreatment of vulnerable patients by the provision of dangerous, non-evidence based treatment;
- (4) the behaviour of Dr Gill at Chelmsford is part of a deeply shameful aspect of the history of psychiatry; and
- (5) in medical circles, it was believed at the time of the Royal Commission that the practice of DST at Chelmsford was an unethical psychiatric practice.

913 As the respondents noted, this evidence is consistent with that of Professor McGorry.

914 As a result, it must be accepted that Dr Gill was held in very low estimation by the relevant sector of society before the publication of the matter complained of. I also accept the respondents' submission that Dr Gill is mentioned only once in the Book which is a further reason to infer that the effect of the publication of the matter complained of on Dr Gill's reputation would have been minimal.

915 Having reached the conclusions that I have, it is neither necessary nor appropriate that I discuss the issue of damages further. My conclusions mean that it is necessary to dismiss both applications.

I certify that the preceding nine hundred and fifteen (915) numbered paragraphs are a true copy of the Reasons for Judgment of the Honourable Justice Jagot.

Associate:

Dated: 25 November 2020

## ANNEXURE A

### SCHEDULE

In respect of the treatment of a psychiatric patient as set out below (**Treatment**):

1. Would a clinician providing the Treatment to a patient:
  - (a) have acted negligently; and/or
  - (b) engaged in medical malpractice; and/or
  - (c) acted ethically; and
  - (d) if the answer to 1(c) above is no, what steps should the clinician have taken to have acted ethically in respect of providing the Treatment?
2. Would the manager of the hospital providing the Treatment, being a general practitioner:
  - (a) have acted negligently; and/or
  - (b) engaged in medical malpractice; and/or
  - (c) acted ethically; and
  - (d) if the answer to 2(c) above is no, what steps should the clinician have taken to have acted ethically in respect of providing the Treatment?

#### **Treatment**

*In the period 1963 to 1978, in a ward (**Ward**) within a small private psychiatric hospital (**Hospital**):*

- (a) *Rendering patients unconscious by an initial dose of barbiturate, and keeping the patient in a barbiturate induced coma for a period of about 14 days by regular maintenance doses of barbiturates and tranquilisers.*
- (b) *The level of unconsciousness to a point where the patient does not react to painful stimuli.*
- (c) *During the coma, patients fed every four hours through a naso-gastric tube.*
- (d) *The manner of toileting being to permit the patients to wet or soil the bed.*
- (e) *From time-to-time patients having periods of semi-consciousness, during which they are able to take some food and use a commode for toileting.*
- (f) *Manual, periodic, repositioning of the patients to stop bed sores, as well as routine suctioning of airways.*
- (g) *Daily administration of ECT without either relaxant or anaesthetic.*
- (h) *At the end of the period of sedation, patients brought back to consciousness by altering the drug regime.*

- (i) *Barbiturates used on patients administered by a registered nurse pursuant to a standard, pre-determined regime prepared as a pro forma for all patients by the treating doctor.*
- (j) *Discretion on the part of the registered nurse to vary what types and what doses of medication given to patients pursuant to the pro forma regime, such discretion exercised with minimal direct medical supervision.*
- (k) *Two assistant nurses on duty in the Ward at one time tending up to 8 unconscious patients.*
- (l) *One registered nurse on duty at any one time for the entire Hospital.*
- (m) *Treating doctors generally only attending on patients once a day to administer ECT, with no doctor ordinarily present in the Hospital at other times.*
- (n) *Treating doctors rarely physically examining or assessing patients whilst receiving the Treatment, nor considering the nurses' notes.*
- (o) *Patients not given a physical or psychological examination prior to the Treatment commencing.*
- (p) *No control studies carried out in respect of the Treatment.*
- (q) *The Ward being equipped with:*
  - (i) *one, and sometimes two, suction machines for clearing the throat of patients;*
  - (ii) *various types of restraints, including wrist straps, restraining sheets and ankle restraints;*
  - (iii) *one oxygen catheter;*
  - (iv) *one oxygen mask; and*
  - (v) *one emergency trolley comprising resuscitation equipment, which was not always kept on the Ward.*
- (r) *Neither the Hospital nor the Ward having:*
  - (i) *x-ray facilities;*
  - (ii) *cardiac monitors; or*
  - (iii) *equipment capable of providing positive pressure ventilation of patients.*
- (s) *Patients not advised of any possible side effects, after effects or risks of the Treatment.*

3. Assuming the other matters set out at (a) to (d) below (**Other Matters**) in respect of the Treatment:
- (a) Would you expect the:
    - (i) clinician providing the Treatment; and/or
    - (ii) manager of the hospital providing the Treatment, being a general practitioner,to have become aware of the Other Matters (at least in an approximate sense)?
  - (b) If your answer to the question above is yes, does this affect the opinions you have expressed in answer to questions 1 and 2 above?

**Other Matters**

- (a) *Approximately 1,115 admission patients received the Treatment between them 1,416 times. Of those patients, approximately 24 died:*
  - (i) *during the Treatment;*
  - (ii) *shortly after receiving the Treatments; and/or*
  - (iii) *as a result of complications arising from the Treatment,**with 66.7% of those deaths being in the age group 20 to 49.*
- (b) *An analysis of a random sample of 200 patients that received the Treatment revealed that those patients suffered side effects during the Treatment, including:*
  - (i) *pyrexia in 48% of patients;*
  - (ii) *cyanosis in 12.7% of patients;*
  - (iii) *the onset of pneumonia in 5.6% of patients;*
  - (iv) *breathing difficulties in 15.9% of patients;*
  - (v) *significant falls in blood pressure in 17.1% of patients;*
  - (vi) *vomiting in 19.9% of patients;*
  - (vii) *urine retention in 17.5% of patients;*
  - (viii) *urinary incontinence in 72.5% of patients*
  - (ix) *faecal incontinence in 6.4% of patients;*
  - (x) *faecal impaction in 11.2% of patients*
  - (xi) *pressure sores in 7.6% of patients; and*

- (xii) *the onset of deep vein thrombosis in 0.4% of patients.*
- (c) *Many patients receiving the Treatment recall suffering serious vivid hallucinations, sleep paralysis and distress from partial consciousness during feedings through a nose tube during the Treatment.*
- (d) *Some patients receiving the Treatment suffering after-effects including:*
  - (i) *loss of balance;*
  - (ii) *long and short term memory loss;*
  - (iii) *tinnitus;*
  - (iv) *hearing loss;*
  - (v) *depression;*
  - (vi) *lethargy;*
  - (vii) *disorientation;*
  - (viii) *learning difficulties;*
  - (ix) *pneumonia*
  - (x) *deep vein thrombosis;*
  - (xi) *pleurisy;*
  - (xii) *pulmonary embolism; and*
  - (xiii) *infections.*