

This is an edited version of the Tribunal's decision. The forensic patient has been allocated a pseudonym for the purposes of this Official Report.

FORENSIC REVIEW:	DARGE	[2024] NSWMHRT 2
	ss 78 / 81 Review of forensic patients <i>Mental Health Cognitive Impairment Forensic Provisions Act 2020</i>	
TRIBUNAL:	Jennifer Boland AM Dr Rosalie Wilcox Dr Susan Pulman	Deputy President Psychiatrist Clinical Neuropsychologist
DATE OF HEARING:	2023	
PLACE:	Mental Health Facility	
CATCHWORDS:	Unconditional release – repatriation – facing criminal sanction in another country on return – prospective application of orders	
LEGISLATION CITED:	<i>Mental Health Act 2007 No 8 (NSW)</i> <i>Mental Health and Cognitive Impairment (Forensic Provisions) Act 2020 (NSW)</i> <i>Migration Act 1958 (Cth)</i> <i>Interpretation Act 1987 (NSW)</i>	
CASES CITED:	<i>Attorney-General for the State of NSW v XY</i> [2014] NSWCA 466 <i>Ban</i> [2013] NSWMHRT4 <i>Omar</i> [2018] MHRT 4 <i>Attorney-General for the State of NSW v XY</i> [2014] NSWCA 466 <i>DRJ v Commissioner of Victims Rights</i> [2020] NSWCA (No 2) 242 <i>Attorney-General of NSW v XY</i>	
REPRESENTATION:	Patient:	Mental Health Advocacy Services

DECISION

1. These are the Tribunal's written reasons for its decision at the hearing held on [date].
2. The Tribunal made the following orders:-

- (1) Pursuant to ss78 and 81 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*, if and when there is compliance with the conditions in Order 2 of these orders, Mr Darge is unconditionally released on leaving the jurisdiction of [State] in his transit to [City], [Country A].
- (2) At all times until his unconditional release Mr Darge is subject to the following conditions:
 - (a) that Justice Health and the Forensic Mental Health Network agree to the provision of funds for the repatriation of Mr Darge to [Country A] including the costs of a four-person escort team.
 - (b) On [date] Mr Darge shall undergo a mental state assessment by Dr A to ascertain his fitness to travel to [Country A].
 - (c) Mr Darge shall take any prescribed medication including PRN medication.
 - (d) Mr Darge is to exercise escorted leave from the [Facility A] to [Airport A] (the airport) on [date].
 - (e) Mr Darge will be escorted by four members of the [Facility A] Staff, including not less than two male staff members (the escort staff) from the [Facility A] to [City] the airport.
- (3) It is noted that Mr Darge will travel with the escort staff on Carrier A/Carrier B Co-share flight scheduled to depart [City] at [time] on [day and date] (with estimated arrival at [Country A] [Airport B] on [day and date]).
- (4) In the event that Mr Darge is considered unfit for travel to [Country A] on [date] or any day prior to that date he shall remained detained in the [Facility A].

SUMMARY

1. Mr Darge is a forensic patient. Mr Darge's current Tribunal order [date] is for detention at the [Facility A].
2. At this hearing, the Tribunal was asked by Mr Darge's treating team to consider making an order for unconditional release.
3. The Tribunal determined it was appropriate to make an order for Mr Darge's unconditional release upon his leaving the jurisdiction of [State] in his transit to [City], [Country A] subject to compliance with a number of pre-repatriation conditions.

STATUTORY CRITERIA

4. At a review of a forensic patient, the Tribunal may make orders about the patient's detention, care or treatment in a mental health facility, correctional centre, detention centre or other place; or conditional or unconditional release: s81 of the MHCIFPA.
5. In reaching its decision, the Tribunal notes that a forensic patient who is ordered to be detained in a mental health facility should, so far as practicable, be detained in a mental health facility or other facility that is appropriate to the patient's needs and appropriate having regard to the safety of the patient and other persons: s70(2) of the MHCIFPA.
6. The Tribunal has had regard to the principles set out in s68 of the *Mental Health Act 2007* and the objects of the MHCIFPA set out in s69 of that Act.
7. Section 84(2) of the MHCIFPA provides that the Tribunal may not make an order for release, unless it is satisfied that that the safety of the patient or any member of the public will not be seriously endangered by the patient's release.
8. Considering whether a proposed release will seriously endanger the community involves consideration of both the probability and the gravity of a risk to the community coming to pass: *Attorney General for the State of New South Wales v XY* [2014] NSWCA 466, Beazley P at [51], Basten JA at [168], McColl JA agreeing.
9. Section 84(1)(a) of the MHCIFPA provides that the Tribunal must also consider whether or not other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the patient or that the patient does not require care.
10. Section 84(1)(b) of the MHCIFPA requires the Tribunal to consider a report from a forensic

psychiatrist or other prescribed class of person who is not treating the forensic patient. The Tribunal has considered the report of Prof B [date], which meets these criteria.

11. The MHCIFPA sets out a number of other matters that the Tribunal must also consider when conducting a review:
 - a) Does Mr Darge have a mental health impairment or cognitive impairment?
 - b) Are there reasonable grounds for believing that care, treatment or control of the person is necessary for the person's own protection from serious harm or the protection of others from serious harm and the continuing condition of the person, including any likelihood of deterioration and the effects of that deterioration: s75 of the MHCIFPA.

EVIDENCE BEFORE THE TRIBUNAL

12. The Tribunal has considered the reports and other documents submitted to the Tribunal either before or at the hearing of this matter and which are exhibits in evidence.
13. It is relevant at the commencement of these reasons to record that there was no contradictor to this application.

Background

14. Mr Darge is a [age] year-old forensic patient who is a [Country A] citizen. His first language is [Language]. He came to Australia in [year] on a tourist visa which expired in [year]. Consequently, he is now an illegal immigrant. Prior to living in Australia, he lived with his family in [City], [Country A]. Mr Darge reports he was physically disciplined by his father as a child. He has a long-standing history of behavioural difficulties as a child and was under the care of a psychiatrist in [City] who diagnosed him with Attention Deficit Hyperactivity Disorder (ADHD).
15. Mr Darge currently maintains contact with, [Person A] by telephone and video link. [Person A] identified herself to the Tribunal using the first name of [Name]. She is her son's nominated carer. [Person A] has been regularly involved with the treating team over the last two years about her son's treatment and welfare and plans for his return to [City].
16. Mr Darge has a diagnosis of schizophrenia, (in remission from [year]) autism spectrum disorder (level 2) major depressive disorder and attention deficit hyperactivity disorder. He has not used drugs or alcohol but is noted to have had a caffeine addiction at age [age] consuming up to eight cups of coffee per night whilst playing video games.
17. In [year] [Person A] brought Mr Darge to Australia as she believed the change would be beneficial for him. Whilst in Australia, [Person A] attended the [Facility B] at [Suburb], [State].

18. On [date] Mr Darge entered the [Facility B] at [Suburb], [State] carrying a [weapon]. When two staff members attempted to remove him from the premises he struck the staff members, including one person who was a [Country A] citizen, causing a fatal [injury]. He had attended the [Suburb] premises the previous day when he physically assaulted [Person A] after she deleted material, which she deemed inappropriate, from his [electrical device].
19. On [date] Mr Darge was served with a notice under s 254 of the *Migration Act 1958* (Cth) notifying him that, on release from the custody of [Facility C], [State] he will be kept in immigration detention until his removal or deportation from Australia.
20. On [date] in the Supreme Court of New South Wales a special verdict of act proven but not criminally responsible of the charge of murder and wound person with intent to cause grievous bodily harm was entered. There are no registered victims.
21. Mr Darge was originally detained in the [Facility D]. He was transferred to the [Facility A], [Ward A], on [date]. He was commenced on Clozapine to treat his acute psychosis, poor insight and risk of harm to himself and others. He has experienced a significant weight gain whilst in detention. At the date of the hearing, he remained in detention on the [Ward A] and had participated in 32 escorted supervised therapeutic outings to local venues including beaches, shopping centres and libraries. One extended visit involved return travel by train to [Town] taking approximately 8 to 9 hours.
22. In [month/year], in accordance with [Country A] law, his parents participated in a mediation and an agreement was reached to pay compensation to the victim's family Mr Darge's parents subsequently paid the victim's family a sum of approximately AUD \$[amount].
23. Mr Darge's [Country] passport will expire in [month/year]. Advice provided by an Immigration lawyer with Legal Aid NSW is that Mr Darge is not likely to be eligible to obtain a bridging visa because of his conviction and having regard to the requirements of the character test under s 501 of the *Migration Act 1958* (Cth). This information has been confirmed in an email dated [date] from [Person B], A/g Manager, NSW Status Resolution – Complex Cases, Department of Home Affairs (Cth).
24. Mr Darge will attain the age of [age] years on [date]. On attaining the age of [age] years he will no longer be eligible to remain in the [Ward A] of the [Facility A] and if he does not return to [Country A], he will require transfer within the forensic system. Because of his immigration status, he is not eligible to receive a NDIS package or Centrelink benefits.

The Application

25. The Notice of Intent received discloses that the treating team are seeking an order for Mr Darge's unconditional release. It is noted under "Details of Order sought" that "We recognise that repatriation to [Country A] is complex particularly as Mr Darge is likely to face criminal sanction in [Country A] for the index offence" but goes on to explain "However, in collaboration with Mr Darge, [Person A] and the Mental Health Advocacy Service, the treating team has endeavoured to ensure that Mr Darge's serious mental illness is considered by the [Country A] Court".

The treating teams reports and the report of an Independent Forensic Psychiatrist

26. There were a number of reports before the Tribunal for the purposes of this hearing. It is relevant that we record aspects of the treating team report, and the report by the independent forensic psychiatrist, Prof B dated [date]. The Tribunal heard oral evidence from [Dr C] (Child, Adolescent and Forensic Psychiatrist) and other members of the treating team as well as from Prof B.

The treating team report and oral evidence before the Tribunal

27. The treating team prepared a comprehensive report for the purposes of this hearing, Oral evidence about recent therapeutic leave and interactions between the treating team and Mr Darge were provided by the social worker and occupational therapist.
28. The report, after setting out background factual matters, notes that Mr Darge meets the diagnostic criteria for schizophrenia and refers to his psychotic symptoms in evidence in [month/year]. These symptoms are noted to have gradually abated following treatment with multiple anti-psychotic medications. He is noted to continue to have an interest in robotics (part of his autism spectrum disorder). Mr Darge is recorded to be accepting of his medications and that over the past four months his insight into his mental illness has markedly improved.
29. The report also explains that Mr Darge meets the criteria for major depressive disorder evidenced by depressed mood most of the day, lack of pleasure from activities, persistent fatigue, worthlessness and recurrent suicidal ideation although he has not acted on these thoughts since his admission.
30. Mr Darge is also noted to meet the criteria for autism spectrum disorder level 2 and that he exhibits entrenched concrete thinking. Dr C opines "His self-construct is poor but he is now more able to hear that others perceive him positively".
31. Other established and possible diagnoses are recorded. Mr Darge has a diagnosis of attention deficit hyperactivity disorder, and the report explains that treating team have considered a

possible diagnosis of oppositional defiant disorder. It is noted Mr Darge's anti-social views developed in the context of his upbringing "which perhaps inadvertently reinforces that violence is an acceptable means to achieve control as evidenced by domestic violence perpetrated by his father".

32. The report sets out Mr Darge's psychiatric history. We note this history is also referred to in Prof B's report and discussed below.
33. The treating team report also provides details of medical investigations carried out during Mr Darge's admission to the [Facility A] including a brain MRI, electroencephalogram (EEG), bloodwork and liver function tests. The report also details fluctuations in Mr Darge's weight He is recorded as having high cholesterol and elevated blood sugar and to suffer from hypertension.
34. The report details activities at the [Facility A] in respect of Mr Darge's education, including that Dr D, psychiatric registrar, engaged with Mr Darge in learning [subject]. During his four-year admission Mr Darge has learned to speak English (and we note he conversed with the Tribunal without the assistance of any interpreter). However, his access to education in the Ward A has been limited only commencing in Term 1, [year]. He ceased to be eligible for formal enrolment in school once he attained the age of [age] and because he is a foreign national. Mr Darge's engagement with education ceased in [month/year] when he became pre-occupied with attempts to access coding/programming websites written in [language] and [language] which the treating team considered may have been unsuitable.
35. It is recorded, as noted under "Background" above, that Mr Darge has never used alcohol, tobacco or any illicit drugs although at age [age] he had a coffee addiction. He is also noted to have no previous criminal record or charges.
36. The report provides a detailed explanation of Mr Darge's experiences and treatment whilst in the [Ward A] including an assault of a fellow patient in [month/year] which his treating psychiatrists attribute to his ASD symptoms. Other aggression is noted to have occurred when Mr Darge engaged in fixed staring and muttering insults directed to a co-patient. Similar behaviour occurred in [month/year], and in [month/year]. On [date] and again in [month/year] Mr Darge was verbally aggressive to staff and initially refused to adhere to a behaviour plan. However, the report discloses since [month/year] there have been no further incidents of physical aggression.
37. It is reported that Mr Darge has been subject to serious incidents of victimisation in the [Facility

A] including a serious assault from a co-patient in [month/year] which necessitated an assessment in hospital when he was [assaulted].

38. The report discloses that during his admission Mr Darge has engaged in individual supportive psychotherapy from [month/year] to [month/year] but his engagement with the therapy was limited and superficial. Further individual psychotherapy has been conducted.
39. Mr Darge is noted to continue to exhibit a “pervasive sense of hopelessness which is partly attribute [sic] to uncertainty about the consequences of repatriation back to [Country A]”.
40. On a positive note, the report explains that Mr Darge has developed a strong therapeutic alliance with the [Ward A's] occupational therapist. As noted above under “Background”, a number of therapeutic outings have been conducted including a leave period of 8-9 hours when Mr Darge engaged in return travel to [Town]. Mr Darge also established a positive therapeutic alliance with the treating team's previous social worker, and he is noted to have engaged positively with the team's new social worker from [month/year].
41. This report, as does the independent forensic psychiatrist's report, explains the risk assessment process conducted by the treating team.
42. The report explains that Mr Darge has been compliant with treatment in the [Facility A] with marked improvement into his mental illness and the nexus between the index offence and his psychotic symptoms. He has expressed sorrow for what happened and has an awareness that he needs to keep taking his medication. Mr Darge is also reported to display an increasing ability to name emotions although he continues to experience shame and remorse identifying himself as a “crazy criminal”.
43. Significantly, the report explains “As a result, [of shame and remorse] Mr Darge remains at risk of future violence, a risk which might increase significantly in a less restrictive setting, unless this is well scaffolded by family and culturally appropriate mental health services. To ensure this occurs Mr Darge needs to return to his family in [Country A]”.
44. Mr Darge's understandable anxiety that he may face criminal sanctions if he returns home is noted. However, the report explains [Person A] and the treating team have worked through the anxieties with him and have developed a comprehensive plan of management for the transition.
45. Under the heading “Legal Issues” the treating team opine that Mr Darge suffers a mental

illness, and although his symptoms have largely abated he still presents with potential risk to himself and others. It is posited that, in the absence of psycho-social support, there is a possibility that he would relapse into psychosis or feel so distressed and isolated that he would seek to end his life. The report explains “He would thus be a significant risk if discharged to the Australian community without adequate support”. In supporting Mr Darge’s repatriation to [Country A], the report notes “If he is released unconditionally to care in [Country A] where his family are able to support him and where care has been arranged, it is likely that this potential violence risk can be attenuated and Mr Darge can lead a pro-social, productive and meaningful life”.

46. In her oral evidence to the Tribunal Dr C emphasised the benefits likely to flow to Mr Darge if he is repatriated to [Country A], but very candidly acknowledged that his historical risk factors for future violence cannot be ignored. However, she expressed the view that she was “fairly confident” that Mr Darge would have extensive opportunities to access further treatment in the community in [Country A], and that he would take up those opportunities.

Prof B

47. Prof B’s report is relied on in these proceedings as a report by an independent forensic psychiatrist under s 84 (1) (b) of the MHCIFPA.
48. Prof B interviewed Mr Darge by AVL on [date]. After referring to relevant background information Prof B summarises Mr Darge’s history noting that, from the information available to him, Mr Darge displayed “preservation, social reciprocity deficits and oppositionality from age [age]”. He further notes the diagnosis of ADHD by Mr Darge’s [Country] child psychiatrist, Dr E, and that he did not take medication prescribed. In [year] Dr E saw Mr Darge again and recommended medication but his parents are noted to have declined and did not attend follow up. Mr Darge is noted to have disclosed suicidal ideation to [Person A] and teacher when he was in Year [X] and [Y] at school.
49. Dr D is recorded as having seen Mr Darge in [month/year] when rigid thinking and “self-talking” was observed. Quetiapine 100mg and zolpidem 10mg was prescribed. One week later Mr Darge is reported to have threatened his parents with a [weapon] when he wanted to use [Person A’s] phone, and he refused medication including risperidone.
50. When seen by Dr D in [month/year] he had not attended school for [months] and medication prescribed was only taken intermittently. Mr Darge is noted to have requested methylphenidate to assist him studying and become rich.

51. Prof B explains that after the index offence and on admission to the [Facility A] Mr Darge described grandiose delusions, he believed his [electrical device] had blueprints for a robotic arm which would replace workers and make him extremely rich after which he would “party wildly until I die ...kill anyone I didn’t like”. At that time Prof D, as his then treating psychiatrist and the treating team, diagnosed Mr Darge with schizophrenia and acute psychotic symptoms. He was commenced on antipsychotic medication, olanzapine, and later prescribed a second anti-psychotic, aripiprazole. His psychotic symptoms resolved in full by [month/year].
52. Prof D explains that during Mr Darge’s X-year detention in the [Facility A] he was “confidently diagnosed with schizophrenia (in remission from [year]) persistent depressive disorder, ADHD and autism spectrum disorder level 2”.
53. At interview, Mr Darge is recorded as saying his psychotic symptoms all resolved three years ago (by [year]). He said he was not studying at the moment because “there is no point” and he endorsed having sad, angry and tired mood. He reported suicide thoughts every day “because my whole life is jail”.
54. Mr Darge is recorded as saying that he would be happier in a [Country A] jail than in the [Facility A] or a medium secure unit. Prof D notes “He understood in [Country A] he may first go to a prison and/or psychiatric hospital and eventually transition to his parents’ home”.
55. Prof D assessed Mr Darge’s risk of violence using the professional judgment tool “*Historical Clinical Risk Management 20 version 3*”. He explained that on the tool Mr Darge had a high loading in five historical scale risk factors. Favourable treatment response for psychotic disorder is noted to be protective and that his most significant historical violent acts occurred when his psychotic disorder was active and untreated.
56. The assessment also revealed a high loading in clinical scale risk factors of insight and a partial loading for symptoms of depressive disorder and autism spectrum and partial treatment responsiveness. The report explains “He had no loading for symptoms of psychosis”.
57. Prof D then discusses scaling risk management scores based on repatriation to [Country A] to prison and/or psychiatric hospital or to his parents’ home. He notes “Moderate loading and relevant for risk management factors including concerns around professional services and plans, his living situation, personal support and treatment compliance. These risks were less concerning in a prison or psychiatric hospital setting. When living at home these risk factors were amenable to mitigation provided he has firm psychiatric treatment plan in place”.

58. Prof D endorses the treating teams' diagnosis noting the care received in the Ward A with Mr Darge's psychosis remaining in full remission for X years that his risk of violence has ameliorated. Significantly, he opines "Mr Darge's overall violence risk was moderately elevated due to largely historical factors, rather than current or recent dynamic issues. Mr Darge's long-standing despondency, hopelessness and current violence risk will not substantially improve with further secure hospitalisation in Australia. Close treatment planning with [Country A] treatment providers is required for repatriation to [Country A] to be a safe therapeutic and contained option for Mr Darge. Once that occurs, then unconditional release is supported as a safe and therapeutic pathway for Mr Darge to progress, return home, reunite with his family and live a life worth living".

Multidisciplinary Management Plan and Risk Assessment for Repatriation via Medical Escort to [Country A]

59. This extremely detailed report set out contacts for various officials as well as details of Mr Darge's proposed psychiatrist in [Country A] and his [Country A] lawyer.

60. The plan provides details of the proposed escort team and repeats information in Mr Darge's lawyer's report (see below). The report also details communication by the treating team with the Executive Officer at the [City]. The plan states that the advice received from the [City] office is that international travellers generally need a valid passport with six months before expiry. The office has advised it will not be providing a renewed [Country A] Passport for Mr Darge however as a [Country A] citizen notwithstanding his passport expires in [month/year] it will not be an issue if he flies before the expiry date.

61. The plan also explains that the treating team are working with the [City] office to have all documentation before the Supreme Court at the special hearing including psychiatric assessments available for the [Area A] District Attorney for future court proceedings as well as certified copies to be provided Mr Darge's [Country A] lawyers, [Person A] and Mr Darge.

62. The plan explains that the treating team has been in contact with Dr F who has agreed to provide ongoing care for Mr Darge in accordance with the [Facility A] treatment recommendations.

Expert and Lay Evidence from [Country A]

63. [Person A] participated in the hearing by AVL from [Country A] and gave evidence with the assistance of a [Language] interpreter. Evidence was also taken by a [Country A] lawyer retained by [Person A] to advise on likely legal outcomes if Mr Darge is returned to [Country A].

[Person A]

64. [Person A] is noted by the treating team to have been closely involved in parenting programs and decision making for her son over the last two years. She has developed a strong relationship with members of the treating team.
65. [Person A] responded to questions posed to her by the Tribunal about proposed accommodation should Mr Darge be granted bail on his return to [City] and/or be released into the community. She explained that the premises, in which the business operated by her, and her husband is located, contains three stories with the top floor comprising a two-bedroom unit which Mr Darge can occupy ([address]). She further explained that she would be closely involved in Mr Darge's care and well-being on his return to [City].
66. The Tribunal found [Person A] to be a sincere and genuine witness and accepted that she is committed to assisting her son, including accessing specialist psychiatric care for him in [City].

Dr F

67. Dr F is psychiatrist and Visiting Staff Consultant from the [Facility E], [Country A]. He provided a report dated [date]. Unfortunately, due to his professional commitments, Dr F was unable to participate in the hearing by AVL from [City].
68. Dr F explains he is willing to accept Mr Darge as a patient, and is aware of his diagnosis (schizophrenia, ADHD, MDD, ASD). He also states that "Since he still needed legal issue in [Country A], I have two clinics a week in [Facility F], which is next to [Facility G]" and further explains that, if Mr Darge is sent to [Facility E], care could be provided once per week. He also explains that psychiatric home care is available if Mr Darge declined to attend the outpatient department. The day care team is noted to comprise "medical doctor, nurse, social worker, occupational therapist and psychologist". Dr F explains that there are many psychiatric daycare rehabilitation centres in [Area A].
69. Dr F also confirms the availability of a number of psychotic and other medications (being Mr Darge's current medications) but notes they do not have berberine, melatonin, myadec, wheat dextrin, olanzapine injection but he says, "I will look up his condition and adjust his medicine".

Person C

70. Person C is a lawyer practising in the firm [Firm A], [address]. He provided a report dated [date]. Person C participated in the hearing by AVL and gave evidence with the assistance of a [Language][interpreter].

71. In his report Person C explains that, on return to [Country A], Mr Darge may be detained at the airport by customs for initial questioning after which he will be transferred to prosecutors in [Area B] for questioning. He opines that there is a “high possibility” of Mr Darge being released on bail because of his own return to [Country A], with no possibility of escape, or destroying evidence of a crime. We pause here to note that the Tribunal was advised that, in [year], a warrant for Mr Darge’s arrest was issued in [Country A]. Person C explains that bail decisions will be made by the court and generally will be completed within 24 hours. He goes on to explain “However, I still cannot completely rule out the possibility of the court imposing a temporary detention order on Mr Darge”.
72. Person C refers to an “investigation stage” when the prosecutor will seek to confirm facts (the attack causing death of the victim) and bring charges against Mr Darge. The matter will then move to the prosecution stage when “the lawyer” will submit specialist mental health reports from Australia concerning Mr Darge’s mental state at the time of the index offence, whereafter on being satisfied of the authenticity of the report, the judge will make a decision “on whether Mr Darge is under psychiatric treatments, and at the same time, through this process, to confirm that Mr Darge is fully recovered”.
73. At para 4 of his report, Person C discussed the current criminal law in [Country A] which provides that “common homicide” may be punishable by the death penalty, life imprisonment, or a term of imprisonment of more than ten years if “there is no mental abnormality at the time of the act”.
74. Person C sets out the criterion which will be assessed by a judge including the offender’s state of mind, the offender’s attitude after the crime, whether a compensation agreement has been reached with the victim (this it appears to mean the victim’s family). He opines that because the compensation payment has been made “that this alone is sufficient to exempt Mr Darge from the death penalty and life imprisonment and even almost 100% likely to get a term of imprisonment of less than ten years’ according to precedents in [Country A]”.
75. Person C explains that it is very likely that the medical assessments conducted in Australia, in which Mr Darge was found not fit to stand trial will be adopted by the [Country A] court, and the court will also take into account the compulsory treatment received in Australia “so as to give him a lighter sentence”.
76. Person C also explains if, on return to [Country A], Mr Darge is found not fit to stand trial, the court process must stop, and no verdict can be entered until his mental state returns to normal.

77. Person C opines that given the compensation paid, it is very likely the court will sentence Mr Darge to a term of imprisonment of less than ten years.
78. The trial process is estimated to be approximately one year in duration with varying estimated time periods provided for proceedings in the Supreme Court (6 months to 2 years). During the currency of the trial period, Person C states “During this period of time, Mr Darge’s personal freedom will be fully protected and will not be interfered with (but he may be restricted from travelling abroad). The Tribunal inferred this information is predicated on Mr Darge being granted bail.
79. Person C also explains that if the court sends Mr Darge to a mental health institution for treatment the institution will report to the court on a regular basis. The maximum period Mr Darge could be detained is five years.
80. Person C concludes his report noting the judicial decisions in [Country A] are made with a humane mindset and that “Personally, I am highly optimistic about Mr Darge’s cases in [Country A] in the future”.

Mr Darge’s views and submissions made by MHAS

81. Mr Darge confirmed at the hearing he wishes to return to [Country A].
82. The Tribunal had the benefit of extensive and helpful written submissions made on Mr Darge’s behalf by the Mental Health Advocacy Service, Legal Aid NSW (the submissions). The Tribunal acknowledges the submissions with thanks.
83. The submissions, at para 6, submit that Mr Darge’s unconditional release, on the basis that he return to [Country A], will not seriously endanger Mr Darge or any member of the public.
84. The submissions highlight a number of matters referred to in Dr C’s treating team report which we have referred to above. The key findings of Prof B’s report are also recorded.
85. Attention is drawn to the Multidisciplinary Management Plan and Risk Assessment and the submissions emphasise that:
 - (1) Mr Darge has no viable options in Australia and (if not returned to [Country A]) will likely remain detained in the [Facility A] or Immigration pending return at some future date. He does not have a visa and is not eligible for supports through Centrelink and or the NDIS.
 - (2) If repatriated Mr Darge will be accompanied by the escort team who have a strong relationship with Mr Darge.

- (3) The proposed flight is a direct one from [City] to [City] with [Carrier A]
 - (4) It is unlikely his behaviour will escalate during the flight.
 - (5) As a warrant has been issued for his arrest he will be detained on arrival and brought before the [Area A] Court.
 - (6) The escort team will notify the Tribunal once handover to [Country A] authorities has occurred.
 - (7) The risk of Mr Darge facing the death penalty is very unlikely.
 - (8) Mr Darge's care and treatment will be handed over to Dr F for ongoing psychiatric care
 - (9) If Mr Darge is released into the community his family have located a property for him to live in near their home and they will provide financial and other daily supports.
86. The submissions address the statutory criteria in s 84 of the MHCIFPA and refer to Beazley P's explanation in *Attorney-General for the State of NSW v XY* [2014] NSWCA 466 at [51] of how "the safety of the patient or any member of the public will not be seriously endangered by the patient's release" is to be applied (see s 84 (2)).
87. The submissions also address the question of who is "a member of the public" noting the proposal is for Mr Darge to be unconditionally released to live in [Country A]. Reference is made to the decisions of the Tribunal in *Ban* [2013] NSWMHRT4 and *Omar* [2018] MHRT 4 as well as the *obiter* comments of Beazley P and Basten JA in *Attorney-General for the State of NSW v XY*.
88. The gravamen of the submission is that the Tribunal should follow the decisions in *Ban and Omar* and that the Tribunal's role in considering the term "member of the public" ... "possibly extends to other persons in Australia, outside of [State], however it does not extend to persons in other countries". It is noted that the two separate Tribunals, in determining how the phrase "member of the public" should be construed, placed on reliance on s 12 (1) (b) of the *Interpretation Act 1987* (NSW) namely that in any instrument "a reference to a locality, jurisdiction or other matter or thing in and of New South Wales" In further support of this interpretation the submissions draw attention to the discussion of Bell CJ in *DRJ v Commissioner of Victims Rights* [2020] NSWCA (No 2) 242 at [10].

DISCUSSION

89. The application for an order for unconditional release, if made, will end Mr Darge's status as a forensic patient in New South Wales.
90. The application raises a number of issues including ones of statutory construction. First, it is necessary to consider whether the decisions in *Ban* and *Omar* should be followed. In summary,

those decisions proceed on the basis that having regard to s 5 (2) and s 12(1) (b) of the *Interpretation Act* 1987 (NSW), as no contrary intention was expressed in the former legislation, the *Mental Health (Forensic Provisions) Act* 1990 (NSW) (repealed), the presumption was that that legislation did not have extraterritorial operation. Accordingly, before granting unconditional release permitting repatriation to another country, the Tribunal in *Ban* held that it *did not* have to have regard to whether “care treatment or control of the patient would be necessary for the patient’s protection in another country or for the protection of others from serious harm in such other country” (see *Ban* at [15]). The Tribunal also explained in *Ban* that the legislature cannot have intended that the Tribunal would have the power to impose conditions which required things to be done in another country which could not be enforced.

91. Secondly, it is necessary to consider if the reasoning in *Ban* can continue to be relied on in light of the obiter comments of Beazley P and Basten JA in *Attorney-General of NSW v XY* and further in light of the comprehensive discussion of the effect of s 5 and s 12 of the *Interpretation Act* by Bell CJ and Leeming JA in *DRJ v Commissioner of Victims Rights*. Relevant in part to this consideration is the reasoning of the Tribunal in *Omar* a decision post dating *Attorney-General of NSW v XY*.
92. Thirdly, if s 84 of the MHCIFPA is applicable to circumstances overseas, has the Tribunal *considered* the probability of risk of harm to Mr Darge and members of the public and the gravity of the risk such that he and the public would not be seriously endangered on his return to [Country A]. This would involve consideration of the death penalty for murder in [Country A], the impact of incarceration in prison or a psychiatric hospital on Mr Darge’s mental state, and treatment in the community. It also involves a consideration of the evidence of Dr C both oral and in the treating team report and the evidence of Prof B.
93. It is also necessary that the Tribunal gives consideration to Mr Darge’s future care and treatment if he remains in New South Wales.
94. The Tribunal accepts that the MHCIFPA does not contain any explicit provision displacing the presumption in s 12 (1) of the *Interpretation Act* (which reflects the position at common law that a statute does not have extraterritorial effect and applies to New South Wales). But we note that at [52] Beazley P in referring to s 43 (a) of the repealed Act (which provided the Tribunal must not make an order for the release of a forensic patient *unless it is satisfied* on the evidence available that the safety of the patient or any member of the public will not be seriously endangered by the patient’s release) said “it should be said however that any member of the public in s 43(a) may extend to any member of the public with whom a patient comes into contact with. For example, if the Tribunal was considering conditional release to

enable a patient to travel overseas, any member of ‘*the public*’ would presumably encompass persons encountered in the course of travelling overseas”.

95. Two matters arise. First, it must be remembered that the President’s comments are made *obiter dicta*, as are those of Basten JA, and that the example her Honour cites refers to conditional release. Thus, the concerns expressed in *Ban* about enforcement of conditions may perhaps be overcome by the Tribunal on notification of a breach of a condition by rescinding the conditional release order. The Tribunal notes this reasoning is consistent with the reasoning in *Omar*.
96. Secondly, s 84 (1) of the MHCIFPA provides that the Tribunal must not make an order for release (including conditional release) of a forensic patient unless *it has considered* the following matters...a report by a forensic psychiatrist...and whether the safety of the patient or any member of the public will be seriously endangered by the patient’s release. The test the Tribunal is required to apply is different to that in the repealed legislation in s 43 (2) which precluded the making of an order unless the Tribunal was *satisfied on the evidence* of the criteria in the section. This latter test remains the test for leave under s 94 of the MHCIFPA.
97. The reasoning in *RDJ* is comprehensive and explores the difficulties in statutory construction in situations such as the instant one. The Tribunal had regard to both the reasoning of Bell CJ at [8-[10] and that of Leeming JA and has taken into account that the Tribunal not infrequently makes orders for a forensic patient to have leave to travel interstate or overseas and in such case it must be satisfied about the matters in s 94 (3) before granting that leave. Again, we note that in these circumstances the Tribunal in permitting a patient to be absent for a period from a forensic facility in New South Wales to travel interstate or overseas is able to enforce conditions imposed by rescinding the leave on notification of a breach and or by the patient’s apprehension (see s 109 MHCIFPA).
98. The Tribunal found the reasoning of the Tribunal in *Omar* at [23] and [28] to be compelling albeit discussing the provisions of the repealed legislation.
99. On balance, and not without some difficulty, particularly in the absence of a contradictor, the Tribunal has concluded that the MHCIFP Act, in the case of an application for unconditional release of a non Australian citizen who is to be repatriated to an overseas country, does not operate extra-territorially to require the Tribunal to consider whether any member of the public living outside of New South Wales will be seriously endangered by the patient’s release. But noting the difference in the wording between s 43(a) and s 84 (1) (b) the Tribunal in the exercise of its discretion must *consider* the probability of risk to the patient who is in New South Wales

being seriously endangered before making an order for unconditional release.

100. In the event we are wrong, and the presumption in s 12 of the *Interpretation Act* is displaced and we are required to consider whether any member of the public in [Country A] will be seriously endangered by Mr Darge's release our consideration is set out below.
101. The Tribunal accepts that Mr Darge has not exhibited psychotic episode since [year] and he has only been involved in one episode of physical aggression during his detention in the [Facility A].
102. The Tribunal was satisfied that there are a number of positive factors likely to enhance Mr Darge's recovery if he is unconditionally released. His sense of hopelessness may be ameliorated particularly with care and support from [Person A]. Mr Darge has responded appropriately in a number of social experiences during his 32 escorted leave outings. Careful plans have been made for transition of his care and treatment from the treating team to Dr F, including access to treatment should he be incarcerated. The Tribunal accepts Prof B's opinion that unconditional release is appropriate where treatment will be provided in [Country A] in the community with minimisation of risk to members of the public in these circumstances. Risk is also minimised if he is detained in jail or a psychiatric facility, noting Dr F's evidence of treatment available if Mr Darge is incarcerated. Each of these matters were considered by the Tribunal and while not ignoring or minimising that Mr Darge has expressed suicidal ideation, the probability of him acting to take his own life, given the proposed treatment and supports, is not high.
103. The Tribunal has also considered whether the care in [Country A] is the least restrictive care appropriate for Mr Darge. This must be assessed in light of his current situation. In New South Wales he will be required to move from the [Ward A] where he has established therapeutic relationships into the general [Facility A] environment which is likely to be very challenging for him. He will not have the benefit of an NDIS program or Centrelink benefits and thus not have access to many programs or activities which would assist his rehabilitation. He is separated from [Person A] with whom he has a close relationship and can only communicate with her weekly by AVL. He is also deprived of his [Country A] culture and customs. On release, he will be taken into Immigration Detention or deported.
104. The Tribunal accepts there are uncertainties about what will occur on Mr Darge's return to [Country A] but notes that even if incarcerated he will have access to psychiatric care, and the more likely scenario is that he will be released on bail pending determination of court proceedings with appropriate psychiatric support. The Tribunal accepts compensation having

been paid to the victim's family the imposition of the death penalty is unlikely to be found appropriate by the courts in [Country A]. Also relevant to this potential punishment is the fact the court in [Country A] will have access to all the material which was before the Supreme Court when Mr Darge was found to have committed the offence of murder but was not criminally responsible. On balance, the Tribunal considered matters relevant under s 84 (1) (a) of the MHCIFPA and formed the view that unconditional release and a return to [Country A] is the least restrictive and safe and effective care for Mr Darge.

105. Finally, although we do not accept it to be the case, should it be necessary for the Tribunal to consider members of the public in [Country A], we have considered on all the evidence before us, particularly having regard to the evidence of Person C about steps which will be taken by the [Country A] judicial system, that members of the public are not likely to be seriously endangered by Mr Darge's release.

DECISION

106. The Tribunal determined it was appropriate to impose a number of conditions for Mr Darge to exercise escorted leave prior to leaving the jurisdiction. On leaving the jurisdiction of New South Wales, Mr Darge is to be unconditionally released.

The Hon. Jennifer Boland AM
Deputy President

Date 18 October 2023