MIGA submission

NSW Law Reform Commission

Review of the *Guardianship Act 1987*

Medical treatment issues

May 2017

[redacted]

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Executive summary

1. In summary, MIGA seeks:

    - clarification of decision making powers of guardians and 'persons responsible' in relation to withdrawal or refusal of life-sustaining treatment

    - statutory recognition of the role of Advance Care Directives (**ACDs**), but on the basis that their validity is determined under the common law and there is no set form or content of an ACD beyond common law requirements

    - clarification of the scope to provide treatment without consent in an emergency situation, including to reflect the existence of any ACD, known patient objections to treatment or well-founded concerns expressed by family members and other loved ones

    - removal of unnecessary documentation requirements for 'persons responsible' providing consent where appropriate documentation is already kept in accordance with, and regulated by, clinical record-keeping requirements

2. Its submission also address a number of the questions posed by the Review in Question Papers 4, 5 and 6 arising out of medical treatment issues.

MIGA's interest

3. MIGA is a medical defence organisation and medical indemnity insurer with a national footprint. It has represented the interests of the medical profession for over 115 years. Its more than 30,000 members and policy holders include significant numbers of medical practitioners practising in New South Wales, both in community and hospital settings.

4. MIGA's lawyers regularly provide advice and assistance to its members and policy holders in dealing with issues relating to guardianship and other issues around substitute decision-making, including capacity, ACDs and working with alternative decision-makers. Its lawyers are experienced in dealing with the varying regimes involving these issues across Australia.

5. Through its Risk Management Program, MIGA educates medical practitioners on a range of medico-legal issues which impact on issues of guardianship, ACDs and other decision-making issues relating to treatment.

6. Recently MIGA has been involved in:

    - the NSW Health Review of Advance Care Directives project (**the ROAD project**)

    - the Victorian Department of Health & Human Services *Simplifying Medical Treatment Decision Making and Advance Care Planning* consultation (**the Victorian consultation**)

    - the Australian Law Reform Commission Elder Abuse inquiry (**the ALRC inquiry**)

Question Paper 5 – Medical treatment issues

Question 2.1: "incapable of giving consent"

(1) Is the definition of a person "incapable of giving consent to the carrying out of medical or dental treatment" in s33(2) of the *Guardianship Act 1987* (NSW) appropriate? If not, what should the definition be?

Yes.

Whether a person is capable of giving consent to the carrying out medical treatment is a question of decision-making capacity.

As set out in MIGA's submission to Question Paper 1:

- in New South Wales, the tests for medical practitioners in assessing decision-making capacity in health care are based on:
    - common law, as explored in cases such as *Hunter New England Area Health Service v A* [2009] NSWSC 761 and *Application of a Local Health District: Re a Patient Fay* [2016] NSWSWC 624
    - clinical judgement, as explained further through the NSW Attorney-General's Capacity Toolkit (**the NSW Capacity Toolkit**), which provides a logical and practical framework for assessing capacity
- practitioners generally have a good understanding of clinical judgement issues involved in assessing capacity
- although practitioners may not be as aware of other issues for consideration, particularly those arising under common law, this is mostly a matter for better education and training, not further legislative clarification
- there is a need for wider dissemination of material along the lines of the NSW Capacity Toolkit, and the development of written and interactive resources for practitioners to consult if required when assessing capacity
- it has significant reservations about providing further legislative clarification about what constitutes decision-making capacity in health care

(2) Should the definition used to determine if someone is capable of consenting to medical or dental treatment align with the definitions of capacity and incapacity found elsewhere in the *Guardianship Act 1987* (NSW)? If so, how could we achieve this?

No.

As indicated in MIGA's submission to Question Paper 1, it is difficult for legislation for address the range of issues to consider when assessing capacity to make decisions about health care.

Issues such as nature of condition, gravity of decision involved, potential consequences, differences between consent to and refusal of treatment, potential considerations of irrationality and reasonableness, and the influences of others can all be relevant to capacity.

It would be very challenging to reduce these wide-ranging elements, the comparative importance of which can vary from situation to situation, to a legislative test in a way that does not compromise or confuse capacity assessments. There is a significant risk of unintended consequences in such a reductionist exercise.

The considerations involved in assessing capacity to consent to health care, as compared with other situations under the *Guardianship Act* when capacity may be an issue on the other, vary widely and involve quite different considerations. There is no compelling reason to reduce the issue of capacity to consent to health care to a simplified definition of capacity which attempts to address all contexts of decision-making, whether in health care or otherwise. This poses considerable risks to those who are the subject of such assessments, and would cause considerable uncertainty for practitioners.

Question 3.1: Withholding or stopping life-sustaining treatment

(1) Should Part 5 of the *Guardianship Act 1987* (NSW) state who, if anyone, can consent to withholding or stopping life-sustaining treatment for someone without decision-making capacity?

Yes.

As observed in MIGA's preliminary submission, there is uncertainty about whether decisions relating to withholding or refusing life-sustaining treatment can be made by guardians or persons responsible under the *Guardianship Act.*

Notably, there is inconsistency in Tribunal decisions on these issues.

It is unclear whether the language of the *Guardianship Act*, particularly the definition of 'medical treatment' under s 33 and the objects of such treatment under s 32, contemplates such treatment including withholding or refusing life-sustaining treatment.

At present, only appointed guardians can make decisions about withholding or refusing life-sustaining treatment. They also require a specific 'end of life health care function' to do so. 'Persons responsible' cannot make such decisions.

The present position is confusing and does not reflect the realities of end of life care.

It is relatively uncommon for a guardian to be appointed to make health care decisions in end of life care situations. It is usually family members, acting as 'persons responsible', who exercise decision making powers.

It is concerning that both practitioners involved in treating such patients and 'persons responsible', each acting in good faith, could potentially be committing offences under *Guardianship Act* because of uncertainty around the powers of a 'person responsible'. This potential scenario must be avoided.

Although it is open for practitioners to rely on the doctrine of futility in withholding or refusing treatment, this is a question of interpretation often involving complex considerations. It does not of itself provide a sufficient basis to guide those involve in end of life care decision-making.

(2) If so, who should be able to consent and in what circumstances?

A 'person responsible' under s 33A of the *Guardianship Act* should be able to consent to withholding or refusing life-sustaining treatment for someone without decision-making capacity.

The circumstances in which such a consent can be given by the person responsible should be based on a test of what is in the patient's 'best interests'. This is the same test which Supreme Court of NSW would apply in determining such an issue under its parens patriae jurisdiction.

Question 3.2: Removing and using human tissue

(1) Should Part 5 of the *Guardianship Act 1987* (NSW) state who, if anyone, can consent to the removal and use of human tissue for a person who lacks decision-making capacity?

No.

Any clarification of these issues should be dealt with under specific legislation, namely the *Human Tissue Act 1983* (NSW).

The issues raised by Question Paper 5 in relation to the removal and use of human tissue involve situations beyond those presently contemplated under Part 5 of the *Guardianship Act.*

Part 5 of the Act deals with medical treatment for the purpose of promoting and maintaining a person's health and well-being. There are differing views and uncertainty over whether this would extend to other clinical decision-making focused on a person's best interests, such as withholding or refusing life-sustaining treatment.

The removal and use of human tissue for the benefit of another person is a different question again.

There is merit in clarifying where and in what circumstances there can be removal and use of human tissue for purposes beyond promoting and maintaining the health and well-being of a particular person, including whether it is in that person's 'best interests'.

In MIGA's view, attempting to deal with these issues in the *Guardianship Act* will be unnecessarily complex and create confusion. In particular, there are issues as to whether the

general principles in s 4 of the Act would fit with removal and use of human tissue for the benefit of others.

As you may be aware, NSW Health has recently undertaken a consultation on the use of ante mortem interventions for organ donation. This includes consideration of whether substitute decision-makers can consent to such interventions.

If any reforms to the *Human Tissue Act* are considered, the terminology used, particularly around substitute decision-makers, should be consistent so far as is possible with the *Guardianship Act*. At present, the *Human Tissue Act* uses the term 'senior available next of kin', not the term 'person responsible' under the *Guardianship Act*, for substitute decision-makers.

MIGA would appreciate the opportunity to consider commenting on medico-legal issues arising out of any further proposals relating to the removal and use of human tissue, whether under the *Guardianship Act*, *Human Tissue Act* or otherwise.

Question 3.3: Treatment by a registered health practitioner

Should the definition of medical and dental treatment in Part 5 of the *Guardianship Act 1987* (NSW) include treatment by a registered health practitioner?

Yes.

Treatment involving a 'health service' as provided by a registered health practitioner under s 5 of the *Health Practitioner Regulation National Law* (NSW) should be included in the *Guardianship Act*.

Question 3.4: Types of treatment covered by Part 5

(1) Are there any other types of treatment excluded from Part 5 of the *Guardianship Act 1987* (NSW) (or whose inclusion is uncertain) that should be included?

Yes.

As set out above, the scope for a 'person responsible' to consent to the withholding or refusal of life-sustaining treatment should be included in Part 5 of the *Guardianship Act*.

(2) Should any types of treatment included in Part 5 of the *Guardianship Act 1987* (NSW) be excluded?

No.

Question 4.1: Special treatment

(1) Is the definition of special treatment appropriate? Should anything be added? Should anything be taken out?

Under s 33 of the *Guardianship Act*, "special treatment" includes the following:

> *any new treatment that has not yet gained the support of a substantial number of medical practitioners or dentists specialising in the area of practice concerned…*

MIGA is conscious of the need to ensure that only clinically appropriate treatments are offered to patients by medical practitioners, particularly those patients who lack capacity to consent to such treatment. Either the Guardianship Division of the NSW Civil & Administrative Tribunal (**NCAT**) or the Supreme Court of NSW should have jurisdiction to deal with these issues.

The difficulty for a practitioner is determining whether a new treatment has support of a substantial number of practitioners in the relevant area of practice.

What constitutes a 'new' treatment, 'support' and a 'substantial number' are terms inherently open to interpretation.

The concept of 'substantial support' differs from the concepts of:

- the defence of treatment widely accepted as competent professional practice to a claim for breach of duty in tort under the *Civil Liability Act 2002* (NSW)
- conduct being significantly below a reasonable standard, constituting unsatisfactory professional conduct under s 139B of the *Health Practitioner Regulation National Law* (NSW).

Although these tests are directed at different contexts, they are parts of a health practitioner's overall duty to a patient. It can be complex and confusing to try and reconcile these concepts.

MIGA proposes that an appropriate body develop guidelines, recognised under the *Guardianship Act*, to inform practitioners on interpretation of this provision. This is something MIGA and other professional stakeholders should be consulted about during its development.

(2) Who should be able to consent to special treatment and in what circumstances?

As set out above, it is appropriate that either NCAT or the Supreme Court of NSW provide consent to special treatment, based on a 'best interests' test.

The exceptions to this are the circumstances set out in s 37 of the *Guardianship Act*, relating to emergencies, based on a test of the patient's 'best interests'.

(3) How should a patient's objection be taken into account?

The common law 'best interests' test takes into account the wishes of a person about proposed treatment, including any objections.

Any valid common law ACD should also be taken into account. This is one of the reasons why MIGA supports recognition of ACDs in the *Guardianship Act*.

The general principles under s 4 of the *Guardianship Act* also provide an appropriate mechanism to consider a patient's objection, namely through the duty to ensure the views of persons who lack capacity are taken into consideration.

(4) In what circumstances could special treatment be carried out without consent?

As set out above, the circumstances provided for in s 37 of the *Guardianship Act*, namely where treatment is required to save a patient's life or to prevent serious damage to their health, are appropriate circumstances for special treatment to be carried out without consent. This should be subject to any valid common law ACD.

Question 4.2: Major treatment

(1) Is the definition of major treatment appropriate? Should anything be added? Should anything be taken out?

The definition of major treatment remains appropriate, subject to the following issues.

The concepts of "*an unusually long period of recovery*" and "*a high level of pain or stress*" are inherently subjective. Consideration should be given to how these could be clarified, whether in the regulation itself or through guidelines developed in consultation with appropriate peak professional bodies.

(2) Who should be able to consent to major treatment and in what circumstances?

A 'person responsible', NCAT or the Supreme Court of NSW, based on a 'best interests' test.

It would only be in unusual situations, such as if there was a dispute between 'persons responsible' or a lack of such a person, that NCAT or Court intervention would be required.

(3) How should a patient's objection be taken into account?

The common law 'best interests' test takes into account the wishes of a person about proposed treatment, including any objections.

Any valid common law ACD should also be taken into account. This is one of the reasons why MIGA supports recognition of ACDs in the *Guardianship Act*.

The general principles under s 4 of the *Guardianship Act* also provide an appropriate mechanism to consider a patient's objection, namely through the duty to ensure the views of persons who lack capacity are taken into consideration.

(4) In what circumstances could major treatment be carried out without consent?

As set out in MIGA's preliminary submission, there is potential for s 37 of the *Guardianship Act* to be read in a way to permit major treatment in an emergency situation even if it is known that the patient objects, or where their family members or loved ones have expressed well-founded concerns about providing treatment.

Obviously this would pose considerable challenges for treating practitioners. It is also questionable whether it is consistent with the emphasis placed on the wishes and input of the patient's family members and other loved ones throughout Australia.

In those circumstances, consideration should be given to:

- whether s 37 of the Act remains consistent with other legal and ethical obligations in relation to treatment in emergency situation
- how to provide further clarification for both practitioners and a patient's family and other loved ones

Question 4.3: Minor treatment

(1) Is the definition of minor treatment appropriate? Should anything be added? Should anything be taken out?

The definition of minor treatment, including any medical treatment which is not special treatment, major treatment or treatment as part of a clinical trial, remains appropriate.

The definition of minor treatment should be extended to cover all 'health services' provided by registered health practitioners under the *Health Practitioner Regulation National Law* (NSW).

(2) Who should be able to consent to minor treatment and in what circumstances?

A 'person responsible', NCAT or the Supreme Court of NSW, based on a 'best interests' test.

It would only be in unusual situations, such as if there was a dispute between 'persons responsible' or a lack of a 'person responsible', that Tribunal or Court intervention would be required.

(3) How should a patient's objection be taken into account?

The common law 'best interests' test takes into account the wishes of a person about proposed treatment, including any objections.

Any valid common law ACD should also be taken into account. This is one of the reasons why MIGA supports recognition of ACDs in the *Guardianship Act*.

The general principles under s 4 of the *Guardianship Act* also provide an appropriate mechanism to consider a patient's objection, namely through the duty to ensure the views of persons who lack capacity are taken into consideration.

(4) In what circumstances could minor treatment be carried out without consent?

Provisions relating to when consent for minor treatment is not required remain appropriate.

The only necessary change is removing the requirement of written certification of certain issues having been considered.

It would be better to include those issues for consideration, namely whether:

- treatment is necessary
- it would be the most successful in promoting the patient's health and well-being
- the patient does not object

as requirements for proceeding without consent.

Otherwise clinical record-keeping requirements under Part 3 of the *Health Practitioner Regulation National Law Regulation (New South Wales) Regulation 2016* are sufficient, without the need for anything further in the *Guardianship Act* or its regulations.

Question 4.4: Treatment that is not medical or dental treatment

Does the *Guardianship Act 1987* deal with treatments that fall outside of the Part 5 regime adequately and clearly?

No.

As set out above, the provisions of *Guardianship Act* should be extended to cover any treatment which is a 'health service' provided by a registered health practitioner under the *Health Practitioner Regulation National Law* (NSW).

Question 4.5: Categories of treatment as a whole

(1) Does the legislation make clear what consent requirements apply in any particular circumstance? If not, how could it be clearer?

Yes, subject to the issues raised above.

The consent requirements are clear with proposed clarifications.

As observed in MIGA's preliminary submission, from our experience in advising and educating members and policy holders on issues arising under the *Guardianship Act*, MIGA is concerned that the Act's requirements are not widely understood.

There is need to consider how health professions can have sufficient awareness of, and access to, relevant material about their obligations under the Act and its regulations.

Helpful information for medical practitioners is available from the NSW Public Guardian,[1] NCAT,[2] and NSW Health.[3]

The challenge is ensuring these helpful resources are known and accessible to practitioners who face significant patient loads and have limited time.

In particular, consideration should be given to use of decision-making tools, such as provided for in the area of child protection,[4] and offering them on a variety of platforms, including apps.

Question 4.6: Person responsible

(1) Is the "person responsible" hierarchy appropriate and clear? If not, what changes should be made?

MIGA's members regularly encounter more than one close friend or relative wanting to act as 'person responsible'.

Clarification of who should be the principal or prevailing 'person responsible', or alternatively how to resolve disputes between persons responsible if there is no primacy, would be helpful for practitioners.

It may be difficult to try and determine an appropriate set of criteria to work out priority in decision-making amongst close relatives or friends.

There is merit in the Queensland approach of attempting to use mediation if decision makers disagree, subject to time constraints.

If agreement cannot be reached, decisions should be made by NCAT or the Supreme Court of NSW.

(2) Does the hierarchy operate effectively? If not, how could its operation be improved?

See answer to question 4.6(1) above.

[1] www.publicguardian.justice.nsw.gov.au/Pages/publicguardian/pg_guardianship/pg_medicalpractitioners.aspx
[2] www.ncat.nsw.gov.au/Pages/guardianship/gt_matter_about_consent_medical_dental.aspx
[3] www.1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2005_406
[4] Such as the NSW Mandatory Reporter Guide – reporter.childstory.nsw.gov.au

Question 4.7: Factors that should be considered before consent

Are the factors a decision-maker must consider before consenting to treatment appropriate? If not, what could be added or removed?

Yes, the factors remain appropriate.

Question 4.8: Requirement that consent be given in writing

Is the requirement that consent requests and consents must be in writing appropriate? If not, what arrangements should be in place?

As raised in MIGA's preliminary submission, there are issues around documentation of treatment consents under s 40 of the *Guardianship Act* and its regulations (particularly regs 12 and 13 of the *Guardianship Regulation 2016* (NSW).

These issues include:

- the requirement for requests to be made in writing - this is unnecessary and impractical in many situations, such as a hospital where contemporaneous records are kept

- a failure to comply with such provisions is an offence under the Act, involving significant penalties beyond those which a health practitioner may face for non-compliance with similar requirements under the *Health Practitioner Regulation National Law* (NSW), or more generally.

Question 4.9: Supported decision-making for medical and dental treatment decisions

(1) Should NSW have a formal supported decision-making scheme for medical and dental treatment decisions?

As indicated in MIGA's submission to the Victorian review, a supported decision-making model reflects developing understandings in Australia, and it supports this approach.

(2) If so, what should the features of such a scheme be?

How a support person is appointed, the extent of their role and obligations, and issues which they should be required to give consideration to, remain to be determined.

It is imperative that health practitioners have a thorough understanding of the role of the support person, who they can be and what both can and cannot do.

If such a model is to be proposed, MIGA would appreciate the opportunity to contribute to any consultation around any proposed legislative model.

Question 4.13: Legislative recognition of advance care directive

(1) Should legislation explicitly recognise advance care directives ("ACD")?

Yes.

Legislation should explicitly recognise ACDs which are valid under the common law.

This is an important part of ensuring that there is no doubt about the relevance of any ACD in relation to issues of guardianship or consent to treatment under the Act.

As set out above, the Act should not prescribe the form or content of an ACD. This should be determined by reference to the common law.

(2) If so, is the *Guardianship Act 1987* (NSW) the appropriate place to recognise advance care directives?

Yes.

Question 4.14: Who should be able to make an advance care directive?

The ability to make an ACD should be the same as that under the common law.

Question 4.15: What form should an advance care directive take?

As set out above, there should be no prescribed form for an ACD.

The only tests for form should be as under the common law, as set out *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

As identified in the context of the Victorian review, MIGA is concerned to ensure that deficiencies in ACD form should not prevent it from being followed if it still complies with common law requirements.

The focus on statutory forms is a shortcoming of ACD regimes in other states.

New South Wales already has a workable and practicable scheme for assessing the validity and applicability of an ACD. The focus should be on:

- improving uptake of ACDs
- increasing the knowledge and availability of relevant and succinct decision-making tools to assist practitioners in determining their validity and applicability in particular circumstances, including through differing platforms such as apps

The work of the NSW ROAD Project in developing a 'template' or 'starting point' ACD is important, but should not progress to the point of becoming an exclusive statutory form of ACD.

Question 4.16: What matters should an advance care directive be able to cover?

Any matters under which ACD can be made at common law.

Question 4.17: In what circumstances should an advance care directive be invalid?

Those circumstance in which an ACD is invalid under the common law.

Question 4.18: Part 5 Offences

(1) Are the various offences of treating without authorisation and the maximum penalties that apply appropriate and effective?

The scope under s 35 of the *Guardianship Act* for any provision of medical treatment that breaches the Act constituting an offence, involving potential civil penalties and criminal liability such as potential imprisonment, is concerning.

Proper protection of those under guardianship or otherwise unable to make their own decisions about health care is imperative. The need to deter inappropriate discharge of functions under the Act is recognised and supported.

The difficultly with s 35 of the Act, as currently framed, is that there is no distinction between breaches based on important factors such as nature of incident and state of mind.

MIGA's concern is for health practitioners who are attempting to discharge their obligations under the Act in good faith, but who may unintentionally and in good faith breach provisions of the Act. These sorts of issues are better dealt with under civil liability and professional regulatory / disciplinary regimes, if required.

MIGA appreciates these cases are unlikely to lead to civil penalties or criminal convictions, but the potential for this remains. It would be preferable to:

- confine civil penalties and criminal liability under Part 5 of the Act to offences involving wilful or reckless acts and / or omissions, and
- provide a 'good faith' defence to criminal liability for health practitioners discharging their obligations under the Act

(2) Is there a need for any other offences relating to medical and dental treatment?

No.

Issues arising from Question Papers 4 and 6

MIGA addresses the following questions posed in Question Papers 4 and 6:

Question Paper 4

Question 4.1: Benefits and disadvantages of a registration system

1. What are the potential benefits and disadvantages of a registration system? Do the benefits outweigh the disadvantages?

MIGA's members and policy holders have faced situations where family members or other carers have asserted the existence of such orders, but they have not been produced.

Alternatively, various family members may have made different assertions about what orders, and their nature, are in place.

As indicated in its submissions to the ALRC inquiry, MIGA supports a register of orders made by guardianship bodies being available for access by medical practitioners. However, it has concerns about how this may work in practice. Issues such as currency, accuracy of information, maintenance of register, privacy and ease of access are examples of the significant factors for consideration in requiring a register. However, the concept of a register has merit.

Although MIGA would support the opportunity to register ACDs, it opposes any registration being a pre-requisite for ACD validity.

The ALRC inquiry issues paper proposed that ACDs be excluded from having to be registered in any enduring documents register. As set out in its submissions to that inquiry, MIGA supports this proposal, so long as there remains scope for a patient to put their ACD on a register if they so wish.

Access to ACDs on a register should be restricted to medical practitioners or others authorised explicitly by a guardianship body.

As proposed to the Commission, MIGA recommends:

- any voluntary register be trialled for a period, say one to two years, before any enduring documents are required to be registered in order to be valid
- guardianship bodies, when making orders, take responsibility for ensuring the ability of a person's treating medical practitioners to access the national register as required
- there be scope for a practitioner to access the register on application to the relevant guardianship body

- if a practitioner needs to access a register as a matter of urgency, there be scope to access relevant documents without direct authorisation

2. Should NSW introduce a registration system?

See answer to question 4.1 (1) above.

3. Should NSW support a national registration system?

See answer to question 4.1 (1) above.

Question 4.2: The features of a registration system

If NSW wants to implement a registration system, what should be the key features of this system?

See answer to question 4.1 (1) above.

Question 7.6: Powers to compel information during investigations

What powers, if any, should the public or peak Guardian or a public advocate have to compel someone to provide information during an investigation?

As set out in its submissions to the ALRC inquiry, MIGA sees health practitioners as one class of persons who may be subject to investigation powers and be required to provide various information relating to their patients.

Given the issues of confidentiality around the therapeutic relationship, and the multiplicity of interests which may be involved in a situation, MIGA believes it is necessary to provide medical and other health practitioners with:

- protections from civil, disciplinary and criminal liability or sanction for acting in good faith in relation to the exercise of any proposed investigation powers

- a reasonable excuse provision for declining or otherwise failing to provide information in response to the exercise of any investigations powers, which would include self-incrimination and issues of practicality

Question Paper 6: Remaining issues

Question 11.1: Supreme Court's inherent protective jurisdiction

What, if anything, should legislation say about the relationship between the Supreme Court of NSW's inherent protective jurisdiction and the operation of guardianship law?

The Supreme Court's inherent jurisdiction, including its parens patriae jurisdiction, should remain unfettered by the *Guardianship Act*.

In issues relating to withholding or refusing treatment and ACDs the Supreme Court of NSW has particular expertise and experience. It should continue to have jurisdiction over them.