THE NAMES AND IDENTIFYING PARTICULARS OF THE APPELLANT AND OF THE OTHER PLAINTIFFS IN THE HIGH COURT PROCEEDINGS ARE SUPPRESSED.

IN THE COURT OF APPEAL OF NEW ZEALAND

I TE KŌTI PĪRA O AOTEAROA

CA677/2017
[2020] NZCA 311

BETWEEN	M (CA677/2017) Appellant
AND	ATTORNEY-GENERAL (IN RESPECT OF THE MINISTRY OF HEALTH) First Respondent
AND	WAITEMATA DISTRICT HEALTH BOARD Second Respondent
AND	CAPITAL AND COAST DISTRICT HEALTH BOARD Third Respondent

Hearing:	5 November 2019
Court:	Clifford, Courtney and Goddard JJ
Counsel:	A J Ellis for Appellant A M Powell and J B Watson for First Respondent D R La Hood for Second and Third Respondents
Judgment:	27 July 2020 at 3.00 pm
Reissued:	4 September 2020

JUDGMENT OF THE COURT

A The appeal is dismissed.

B There is no order as to costs.

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REASONS OF THE COURT

(Given by Goddard J)

Introduction

[1] Mr M is intellectually disabled. He also suffers from a personality disorder with borderline antisocial and narcissistic personality traits. From December 2001 to July 2007 he was detained as a special patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH Assessment and Treatment Act). From July 2007 until June 2009 he was detained as a special care recipient under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID Care and Rehabilitation Act). In June 2009 the Family Court made a compulsory care order in relation to Mr M under the ID Care and Rehabilitation Act. His status as a care recipient under that Act continued until December 2013.

[2] In these proceedings Mr M challenges numerous aspects of his detention under the MH Assessment and Treatment Act and the ID Care and Rehabilitation Act. He says that the operation of the statutory provisions authorising his detention was unlawfully discriminatory in breach of s 19 of the New Zealand Bill of Rights Act 1990 (NZBORA). He seeks declarations that aspects of his treatment while detained constituted torture or were cruel and inhumane, in breach of ss 9 and 23(5) of NZBORA. He also claims his detention has been punitive rather than protective and was, or became, arbitrary in breach of s 22 of NZBORA. Underpinning many of these claims is an argument that the way in which Mr M has been treated under the

legislative schemes that applied to him at various times is inconsistent with his rights under the Convention on the Rights of Persons with Disabilities (CRPD), to which New Zealand is a party.[1] Mr Ellis, counsel for Mr M, says that the CRPD is an important source of guidance when interpreting and applying the provisions of NZBORA on which he relies. It requires a "paradigm shift" in the legal treatment of persons with disabilities.

[3] In the High Court Mr M's claims were heard together with similar claims by Mr S and Mr C at a six-week trial before Ellis J. The Judge delivered a 264-page judgment which carefully reviewed, and dismissed, those claims.[2] Mr M now appeals to this Court.

[4] We have not been persuaded that the Judge erred in any of the respects advanced by Mr Ellis on behalf of Mr M. It would be wrong for us not to acknowledge the Judge's thorough, intellectually rigorous, and compassionate analysis of the claims. It is neither necessary nor appropriate for us to carry out an equally detailed and lengthy examination of all the issues raised by these proceedings. Rather, we will endeavour to briefly set out, in relation to each of the issues raised before us, the Judge's findings, the appellant's arguments, and the reasons why we have not been persuaded to differ from the Judge. In doing so we mean no disrespect to the wide-ranging and thought-provoking submissions of Mr Ellis. But where an appellate court has little or nothing to add to the reasoning of the first instance Judge, a lengthy repetition of the Judge's analysis serves no useful purpose.

The facts

[5] There was no challenge to the factual findings made in the High Court. The description that follows of the events giving rise to Mr M's detention under the MH Assessment and Treatment Act and the ID Care and Rehabilitation Act, and the circumstances of his detention pursuant to those statutes, is drawn from the High Court judgment at [167]–[187].

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1 United Nations Convention on the Rights of Persons with Disabilities 2515 UNTS 3 (opened for signature 30 March 2007, entered into force 3 May 2008).

2 *S v Attorney-General* [2017] NZHC 2629 [High Court judgment].

Background and key events

[6] Mr M was born in Auckland in 1967. Both his parents had intellectual disabilities, as does his sister. He has a history of being physically and sexually abused. Mr M and his sister were made wards of the state in 1971 due to neglect in the home. They lived in a number of welfare homes prior to his admission to Māngere Hospital. Mr M's childhood was a very adverse one.

[7] Mr M's first admission to a psychiatric hospital was in 1985. His first contact with the criminal justice system was in 1990 when, after a conviction for arson, it seems he received a two-year prison sentence. After serving that sentence, Mr M spent 14 months at Tōtara Trust, a psychiatric rehabilitation unit. During this time, Mr M was charged with assault with a weapon after allegedly threatening his sister with a knife and cutting her on the hand.

[8] Mr M was charged with a further arson in 1994. He was found to be under disability and was admitted to the Mason Clinic. He was eventually discharged and lived in supported accommodation.

[9] In 1995 he was again charged with criminal offences: wilful damage and assault. It was alleged that he smashed a car with a baseball bat and attempted to hit his caregiver. He was again found to be under disability, and was readmitted to the Mason Clinic, although he returned to the community relatively quickly.

[10] Between 1996 and 2000, Mr M resided in accommodation managed by Spectrum Care (an independent charitable trust that provides support for people with disabilities). He was discharged because he consistently displayed challenging behaviours, such as property damage, aggression toward staff, drug and alcohol use, and inappropriate sexual conduct.

[11] On 1 September 2001 Mr M was charged with assault with intent to rob. On that occasion, he threatened a taxi dispatcher with a large screwdriver and said "give me the cash or I'll stab you". He was found to be under disability pursuant to s 115(1)(a) of the Criminal Justice Act 1985 (CJA). On 20 December 2001 he was ordered to be detained as a special patient under the MH Assessment and Treatment

Act at the Kauri Unit in the Mason Clinic. That status was continued on 10 April 2002, 23 July 2002, and 9 October 2002.

[12] On 8 October 2002, Mr M was transferred to the Te Huia Unit at Porirua Hospital. His special patient status was reviewed and continued on 24 March 2003. He was subsequently transferred between the Te Huia and Pūrehurehu Units, and then to the Rangipapa Unit. The evidence of Dr Judson, who was involved in Mr M's care, was that:

> He was a very difficult person to deal with when he was in Te Huia. Again my recollection was that he was … targeting people and threatening and intimidating … staff and other clients within the unit. … when he did assault or exhibit violence he was actually quite a handful to manage, he's a very strong unit is [Mr M], as I recall particularly well.

[13] Dr Judson's specific recollection of Mr M's strength related in particular to an assault on him on 2 September 2003. Dr Judson describe the event in this way:

> [Mr M] had been threatening me for some time before this happened because he saw me as being the person who's responsible for him being in Te Huia and not in Auckland. I think there'd been attempts to explain to him that actually these decisions were being made elsewhere but I was the doctor. He saw me as being the boss. Because of the threats, he was on very close observation to make sure that nothing happened but somehow or other, you know, there was a brief moment where he was out of sight and targeted me. He punched me, got me on the floor and then he tried to gouge out my eye. It was pretty frightening.

[14] Mr M's status as a special patient was reviewed and continued on 12 March 2004. On 1 September 2004 Mr M continued to be detained as a special patient under the MH Assessment and Treatment Act (but now pursuant to s 24(2)(a) of the new Criminal Procedure (Mentally Impaired Persons) Act 2003 (MI Criminal Procedure Act)). On 14 October 2004 he transferred to the Pūrehurehu Unit.

[15] Mr M was admitted to the newly opened Haumietiketike Unit in January 2005. His status as a special patient was continued on 8 March 2005, September 2005 and 10 March 2006.

[16] In July 2006 Mr M transferred from Porirua back to Auckland, and was admitted to the newly opened Pōhutukawa Unit. His status was reviewed and continued on 29 September 2006. On 5 April 2007 his responsible clinician considered that while Mr M remained unfit to stand trial, it was no longer necessary for him to have special patient status. The following month he was transferred to the Kauri Unit but he returned to the Pōhutukawa Unit soon thereafter.

[17] On 6 July 2007 Mr M was transferred pursuant to s 47A of the MH Assessment and Treatment Act from special patient status under that Act to special care recipient status under the ID Care and Rehabilitation Act. That status was continued on 12 January 2008, July 2008 and 19 December 2008.

[18] Following the expiry of half the maximum (14 year) sentence for the assault with intent to rob charge on 20 December 2008, on 14 January 2009 the Attorney-General gave a direction under s 31(4) of the MI Criminal Procedure Act that Mr M be held as a care recipient under the ID Care and Rehabilitation Act.[3]

[19] On 29 June 2009 the Family Court made an order under s 85 of the ID Care and Rehabilitation Act extending Mr M's status as a care recipient for 12 months, and directing that he receive compulsory secure care.[4] Judge Adams' judgment records that the hearing was attended by 14 people, including both a lawyer and support person for Mr M, a member of the Justice Action Group (JAG), the District Inspector, four representatives of the Regional Intellectual Disability Care Agency (RIDCA), Dr Duff as the specialist assessor, the Pōhutukawa Unit Manager, Mr M's care manager, a psychiatrist and a social worker.

[20] Mr M's status was reviewed and continued on 23 December 2009, 31 January 2010, and 13 June 2010. His frustration at his continued detention led to a number of incidents of violence. His compulsory (secure) care order was further extended by Judge Hikaka for two years on 6 October 2010.

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3 Crimes Act 1961, s 236(1).

4 *Regional Intellectual Disability Care Agency v [M]* FC Manukau FAM-2008-092-386, 29 July 2009.

[21] His status was again reviewed and continued on 30 March 2011 and 26 September 2011. On about 1 February 2012 Mr M began a transitional process to Tīmata Hou in Auckland. He was discharged from the Pōhutukawa Unit to Tīmata Hou on 11 June 2012.

[22] His status as a care recipient was reviewed and continued on 2 October 2012. His compulsory care order was again reviewed on 17 December 2012 and was extended for one year, but with supervised, rather than secure, care. On 17 December 2013 Mr M's compulsory care order expired and, deliberately, no further extension was sought. It appears that since then he has been living in supported accommodation in the community.

Mr M's presentation

[23] Mr M has a low IQ combined with a well-established personality disorder. Dr Duff, who was the Responsible Clinician for Mr M before his transition to community care, said in evidence that Mr M's aggression towards others related to his developmental deficits, rather than a lack of a theory of mind flowing from autism spectrum disorder (as was the case with the other plaintiffs in the High Court). But although Mr M was the only one of the plaintiffs without autism, Dr Duff said he was an equally (but differently) complex and difficult patient to manage and treat:

> … by virtue of the abusive experiences he had in his background, the lack of normal upbringing or normal childhood, the complex ways in which he survived through the years.

[24] Dr Duff commented on Mr M's presentation during his DVD interview as follows:

> Yes, so on the DVD, from a clinical perspective [Mr M] has … an underlying sadness which is … reflected in the reports where people talk about their depressive element there as well and this traumatised, abused, very regressed young person in an old body is a pervasive feature of [Mr M]'s presentation and I think that that kind of simplistic, you know my needs and wants are very … basic and that sadness … comes across on the DVD quite forcefully. What doesn't come across … is … the rage and anger that [he] feels when he feels that people aren't doing what he wants them to do. So … he talks frequently on the DVD for example about the reason why he went to [seclusion] because staff didn't listen and I don't think that it's because staff didn't listen, it's because staff didn't do what he wanted them to do and so that's, you know it's

> not a definition of not listening, not giving him what he wants but his view … is … quite a child-like interpretation of the world around you …

[25] Then, Dr Duff went on:

> But when he is very angry about something he is a very terrifying man and again there's just hints of it within the clinical documentation but again this was reflected in his peers and how his peers reacted to [Mr M] as well where people didn't want to be on the wrong side of [Mr M] because when he was in a rage then that was [a] very frightening experience for peers or for staff or for visitors around him and yet he's capable of being a really charming, engaging person as well …

[26] The evidence was that Mr M tends to externalise blame and minimise his actions. There was a level of pre-meditation to Mr M's violence and, as indicated above, the victims of his violence tended to be people who had not immediately met his needs as he perceives them. Mr M has also assaulted his peers. As well as being, at times, highly aggressive and violent, at other times he would be systematically destructive:

> … he would peel the lining off walls, he could unscrew screws with his bare hands, even countersunk screws, so he could take things apart. And … he's a patient man when he's engaged in doing what he's wanting to do so he would be systematic, … that's not rageful behaviour, it's not that he's a whirling dervish, destroy the room, this is a I'll start in one corner, I'll start peeling the covering off or I'll start tearing up the floor piece by piece until it's completely destroyed or until they have to come in to stop me … and on more than one occasion and not just seclusion rooms, so his bedroom area, other things when he was cross about things he would destroy … sometimes it would be his own belongings, ripping up clothes, taking things to pieces, kind of a slow burn ...

Issues on appeal

[27] The appeal raises 10 main issues. The appellant submits that:

(a) *Unfair hearing and wrong burden of proof*: The Court should not have made findings that Mr M had been involved in acts of violence that were not the subject of criminal charges. He is entitled to the presumption of innocence. Moreover the burden of proof should have been on the respondents to disprove ill-treatment, not on Mr M to prove it.

(b) *Litigation guardian appointment*: The requirement to have a litigation guardian in these proceedings is contrary to the CRPD and is unlawful. The Judge erred in finding that an earlier judgment of Ronald Young J in these proceedings, which held that the litigation guardian rules were lawful and valid,[5] was res judicata and could not be revisited.

(c) *Sexual activity*: The Judge should have found that the absence of a written policy on sexual relationships meant the policy was uncertain and not prescribed by law. The policy prohibiting sexual relationships for detained persons was inconsistent with ss 9 and 23(5) of NZBORA.

(d) *Guidelines under the MH Assessment and Treatment Act and the ID Care and Rehabilitation Act*: Declarations should have been made in relation to the alleged invalidity of guidelines under s 130 of the MH Assessment and Treatment Act, and the absence of guidelines under s 148 of the ID Care and Rehabilitation Act.

(e) *Discrimination and arbitrary detention*: Mr M's detention because he was found to be unfit to stand trial was discriminatory and arbitrary, in breach of ss 19 and 22 of NZBORA.

(f) *Unlawful Executive detention*: section 76 of the MH Assessment and Treatment Act, which provides for clinical reviews of patients, gives rise to unlawful detention by the Executive.

(g) *Right to second opinions*: There were failures to advise Mr M of his right to obtain a second opinion from a medical practitioner in respect of medical assessments, in breach of his rights under NZBORA.

(h) *Breach of Convention against Torture*: Mr M's detention was in breach of art 11 of the Convention against Torture (CAT).[6]

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5 *S v Attorney-General* [2012] NZHC 661.

6 United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1465 UNTS 85 (opened for signature 10 December 1984, entered into force 26 June 1987).

(i) *Failure to give NZBORA Rights prior to medical assessments*: The Judge should have found that before undertaking medical assessments forming the basis of continued detention, Mr M should have been advised of his rights under ss 11 and 27 of NZBORA and under the CRPD.

(j) *Totality*: The conduct that is the subject of the other grounds of appeal, taken as a whole, amounts to breaches of Mr M's rights protected by NZBORA.

[28] Each of these grounds is addressed below.

The legal framework for determining Mr M's claims

[29] Before turning to the specific grounds of appeal, we make some observations about the legal framework that applies to Mr M's claims.

[30] First, these are ordinary civil proceedings in which the burden of proof lies on the plaintiff — Mr M — to establish the relevant facts, and to identify a proper legal basis for the relief sought.[7]

[31] Second, it is not the role of a court to determine abstract questions of law divorced from the facts of the case before it. Some of the issues that Mr Ellis sought to raise — for example, the fourth ground of appeal in relation to the failure to issue seclusion guidelines under s 148 of the ID Care and Rehabilitation Act — never affected Mr M personally, and will not affect him in the future as he is no longer subject to the ID Care and Rehabilitation Act. It would not be appropriate for this Court to determine issues, or grant relief, in these proceedings in relation to questions that are of no practical relevance to Mr M. Similarly, some issues were the subject of factual findings by the High Court that were fatal to the claim advanced on behalf of Mr M, and that Mr Ellis did not seek to challenge by reference to any evidence before the Court. Where a claim plainly cannot succeed on the facts, it is not appropriate for

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7 *Brown v Attorney-General* [2005] 2 NZLR 405 (CA) at [26].

the court to engage in a lengthy analysis of legal issues that might be relevant in another case, on different facts.

[32] Third, many of the grounds of appeal that Mr Ellis advanced before us involved challenges to the legislative frameworks that apply to mentally impaired persons charged with a criminal offence. Those challenges were advanced by reference to NZBORA and the CRPD. In some cases Mr Ellis argued that a particular interpretation of a statutory provision — for example, ss 30 and 31 of the MI Criminal Procedure Act — should be adopted in order to ensure compliance with NZBORA. Section 6 of NZBORA provides that wherever an enactment can be given a meaning that is consistent with NZBORA, that meaning should be preferred to any other meaning. We adopt that approach.

[33] Fourth, the Supreme Court has confirmed that the courts can, in an appropriate case, make a declaration that a statute is inconsistent with NZBORA.[8] It is therefore open to this Court to entertain Mr M's claims for declarations that certain statutory regimes that apply to intellectually disabled persons are inconsistent with NZBORA.

[34] Fifth, in support of certain grounds of appeal Mr Ellis submitted that statutory provisions, and the provisions of NZBORA itself, should be given an interpretation consistent with the CRPD. It is well established that legislation should be interpreted having regard to New Zealand's international obligations, and should so far as possible be read in a manner that is consistent with those obligations.[9] Again, we adopt that approach.

[35] Sixth, and at the risk of stating the obvious, under New Zealand law international instruments do not prevail over primary legislation. A court cannot decline to apply an Act of Parliament, or give a provision in a statute a strained meaning that is simply not available having regard to its text and purpose, in order to reach a result that the court considers would be more consistent with an international

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8 *Attorney-General v Taylor* [2018] NZSC 104, [2019] 1 NZLR 213.

9 *Tavita v Minister of Immigration* [1994] 2 NZLR 257 (CA) at 266; *New Zealand Air Line Pilots' Association Inc v Attorney-General* [1997] 3 NZLR 269 (CA) at 289; *Huang v Minister of Immigration* [2009] 2 NZLR 700 (CA) at [34]; and *Ye v Minister of Immigration* [2009] NZSC 76, [2010] 1 NZLR 104.

instrument. In particular, the CRPD does not override New Zealand legislation. Where a New Zealand statute clearly provides for a particular outcome, that outcome is lawful even if it is not consistent with the CRPD.

[36] Seventh — a related point — it is not the role of the New Zealand courts to make findings about whether New Zealand legislation is consistent with international instruments such as the CRPD. If the legislation that governs a particular issue is clear, then it is neither necessary nor appropriate for this Court to go on to make findings about the consistency of that legislation with the CRPD.

[37] Against that backdrop, we turn to consider the ten grounds of appeal advanced by Mr Ellis on behalf of Mr M.

First ground of appeal — unfair hearing, wrong burden of proof

Appellant's argument

[38] This ground of appeal combines two different complaints about the approach adopted in the High Court.

[39] First, Mr Ellis submits that Mr M is entitled to the presumption of innocence. However he was denied the benefit of that presumption, and of equality before the law, by the Judge's reference to allegations of violence that he had not had an opportunity to defend at a trial. By way of example, Mr Ellis refers to paragraph [2] of the judgment, which reads:[10]

> [2] Historically, all three men have been charged with violent offending of a moderately serious kind. They have also been involved in many other acts of violence that have not been the subject of criminal charges. Their respective disabilities meant that, for the period covered by their claims, they were not dealt with through the criminal justice process. Rather, they have been detained and treated in medium secure forensic hospital units controlled and operated by the Capital and Coast District Health Board (CCDHB) and Waitemata District Health Board (WDHB), on the grounds that their clinicians and the Courts have considered that they continue to pose a risk of harm to others and to themselves.
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> (Footnote omitted).

10 High Court judgment, above n 2.

[40] Second, Mr Ellis submits that this is an ill-treatment case, and that in circumstances where the events in issue lie wholly or in large part within the exclusive knowledge of the authorities, the burden of proof should have been on the respondents to disprove ill-treatment, not on Mr M to prove it. Mr Ellis referred to the decision of the European Court of Human Rights in *Mammadov (Jalaloglu) v Azerbaijan* that:[11]

> Where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons within their control in custody, strong presumptions of fact will arise in respect of injuries occurring during such detention. Indeed, the burden of proof may be regarded as resting on the authorities to provide a satisfactory and convincing explanation.

Analysis

[41] The complaint that the Judge made findings that Mr M had engaged in acts of violence that had not been the subject of criminal charges, and that such findings were inconsistent with the presumption of innocence, is misconceived. The rights affirmed by s 25 of NZBORA apply to "[e]veryone who is charged with an offence". This Court has previously identified the possibility that s 25(c) of NZBORA is not confined to trial procedure, and could be breached by official pronouncements in other settings of the guilt of a person charged.[12] But Mr M was not charged with an offence in these proceedings or in any other live proceedings. Rather, he brought civil proceedings about the circumstances of his detention, and those proceedings raised issues that the court needed to determine about how he was treated, and why he was treated in that way. The presumption of innocence that applies in relation to criminal charges was not relevant in that context.

[42] The specific paragraph that Mr Ellis identifies as problematic is a summary of more detailed findings made later in the High Court judgment on the basis of evidence given by clinicians who had witnessed, and in one case been the victim of, acts of violence by Mr M. These factual findings were relevant to a number of aspects of the proceedings, including complaints about the use of seclusion and restraint. The Judge found that the clinicians attending Mr M sought to assist his rehabilitation and make him as comfortable as possible, but a substantial impediment they and Mr M faced

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11 *Mammadov (Jalaloglu) v Azerbaijan* ECHR Application 34445/04, 11 January 2007 at [62] (footnotes omitted).

12 *R v Coghill* [1995] 3 NZLR 651 (CA) at 662.

was the manifestation of his distress in acts of violence, putting him and the staff dealing with him at risk. As the Crown says, it is no surprise that the clinical treatment of a patient with a low IQ combined with a well-established personality disorder who was, at times, aggressive and violent, and at other times systematically destructive, is affected by the behaviour of that patient. The findings on violence formed part of the circumstances of Mr M's detention, and were therefore relevant to the determination of some of the claims made in this proceeding.

[43] Nor was there any error in the Judge's approach to the burden of proof in these proceedings. These are civil proceedings alleging an infringement of rights guaranteed by NZBORA. As with all civil proceedings, the plaintiff has the burden of establishing its case on the balance of probabilities. In this case, Mr M had to prove on the balance of probabilities that his rights protected by NZBORA had been infringed by the legal regime that applied to him, or by the conduct of one or more of the respondents.

[44] The parties and the Judge were very much alive to the difficulties that Mr M faced in giving evidence because of his disability. Extensive measures were taken to facilitate the giving of evidence by Mr M and the other plaintiffs.[13] The facts of Mr M's detention were established largely from the clinical records before the Court. The clinicians involved gave detailed evidence explaining and justifying the decisions they took, where those were challenged. Mr M's claims were not dismissed because the Judge erred in relation to the burden of proof. Rather, they were dismissed because the Court accepted the evidence of the clinicians on certain issues, and on other matters there simply was no evidence to support the allegations made.

[45] We do not accept the submission that the approach in cases such as *Mammadov (Jalalogou) v Azerbaijan* is relevant to the matters that Mr M was required to establish in these proceedings. In cases where a detained person who brings a claim of ill-treatment presents with injuries that occurred during detention, the injuries may speak for themselves and the evidential burden may shift to the detainer to provide an explanation for those injuries. The legal burden does not shift, but the plaintiff can

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13 High Court judgment, above n 2, at [26]–[31].

easily meet it. No issue of that kind arose here. Mr M did not suffer harm while he was detained of a kind that called for an explanation on the part of those responsible for his care.

[46] This ground of appeal is misconceived, and cannot succeed.

Second ground of appeal — appointment of litigation guardian

The issue

[47] When the proceedings were first filed in the High Court in March 2010 an application was made to commence the proceedings without a litigation guardian. Dobson J declined that application on the grounds that, given the plaintiffs' disabilities, r 4.30 of the High Court Rules 2016 required a litigation guardian to be appointed.[14] Following that decision, Mr Colin Burgering was appointed as litigation guardian for all three plaintiffs.

[48] Subsequently the plaintiffs filed a further application seeking to dispense with their litigation guardian and seeking a declaration that r 4.30 was unlawful. Ronald Young J held that r 4.30 was not discriminatory and did not breach the CRPD, so was not unlawful.[15] He held the rules did not limit the rights of intellectually disabled people to access the courts. Rather, he said that the litigation guardian procedure facilitated their equal access. He considered the CRPD anticipated such an accommodation.

[49] Mr Burgering continued to act as Mr M's litigation guardian until his death in February 2017. Mr Michael Bott was then appointed as Mr M's litigation guardian.

High Court judgment

[50] Mr Ellis sought to relitigate the lawfulness of r 4.30 before the Judge at trial.

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14 *S v Attorney-General* HC Wellington CIV-2010-485-379, 22 June 2010 (Minute of Dobson J).
15 *S v Attorney-General*, above n 5, at [39]–[47].

[51] The Judge declined to entertain that argument. She considered the issue was res judicata: it had already been decided by Ronald Young J.[16] The finding had been made in relation to the same proceedings and as between the same parties. The plaintiffs could have appealed from the judgment of Ronald Young J, but did not do so.

Appellant's argument

[52] Mr Ellis argued that the finding that the topic of guardianship was res judicata missed the point. This finding meant it was impossible to periodically revisit the question of guardianship, which "effectively became disability cast in stone". Logically, he said, regular periodic reviews of disability are required. Mr M was no longer detained under any legislative scheme, and his need for a litigation guardian should have been revisited.

Analysis

[53] Mr Ellis' submissions run together two quite distinct issues.

[54] The first issue is whether the rules requiring a litigation guardian to be appointed are lawful. Ronald Young J found that they were. Ellis J found that the issue was res judicata before her. Mr Ellis has not identified any error in the Judge's finding that the issue of the validity of r 4.30 was res judicata, and could not be revisited at trial. Mr Ellis accepted in the course of argument that all the elements of res judicata were present in relation to this issue. We consider that the Judge's finding on this issue was plainly right.

[55] The second issue is whether Mr M's circumstances changed over time, with the result that a litigation guardian was no longer required. Nothing in the judgment of Ronald Young J precluded that issue being revisited. Indeed it was suggested in his decision that this question (and the relevant medical evidence) could be explored at trial if the plaintiffs wished to do so. But as Ellis J recorded, that did not occur.[17]

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16 High Court judgment, above n 2, at [20].
17 At [15] and footnote 11.

[56] It was always open to Mr M to apply to continue the proceeding without a litigation guardian on the basis that his circumstances had changed, and he had ceased to be incapacitated. Indeed if that was the case, his litigation guardian had a responsibility to draw the change in circumstances to the attention of the Court. But no steps were taken by Mr M's litigation guardian, or by his counsel, to raise the issue of a change in circumstances. Mr Ellis confirmed to us that there was no formal application to dispense with a litigation guardian in the course of the trial, and that no evidence was provided at trial on the issue of Mr M's capacity.

[57] In the absence of such an application, the Judge did not err in failing to consider whether circumstances had changed in a manner that removed the need for a litigation guardian. That issue was never live before her.

[58] As the argument developed before us, Mr Ellis emphasised the absence of any provision in the High Court Rules for regular review of a party's capacity. He submitted that it is wrong to punish a client if counsel fail to make an application for such a review. However such an application could have been made at any time, if Mr M's litigation guardian or counsel considered that it was appropriate to do so. There was no barrier to them doing so. They had access to relevant information about Mr M's circumstances. In the absence of an application and supporting evidence, the Court did not have access to that information. The Court was not required to raise the issue of its own motion. Nor would any useful purpose be served by providing for regular reviews in the High Court Rules: rather, the responsibility for raising the issue rests with the individual's litigation guardian, who can (and should) do so if and when it arises.

[59] This ground of appeal also fails.

Third ground of appeal — sexual activity

The issue

[60] The forensic unit where Mr M was detained operated a policy that sexual relationships between patients were prohibited. That policy was not in writing, but

as the Judge found, it was very clear and was well understood by staff in the unit.[18] Patients were told explicitly that sexual activity was not permitted.

[61] In the High Court the plaintiffs alleged that the respondents had breached ss 9, 14 and 23(5) of NZBORA because:

(a) The plaintiffs had been unlawfully deprived of the ability to enter into sexual relationships, to marry, and to start a family.

(b) The respondents failed to implement policies for the provision of adequate sexual education and for sexual conduct involving patients.

(c) The plaintiffs' private sexual activities had been unlawfully interfered with.

[62] Sections 9, 14 and 23(5) of NZBORA provide as follows:

> **9 Right not to be subjected to torture or cruel treatment**
>
> Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment.
>
> **14 Freedom of expression**
>
> Everyone has the right to freedom of expression, including the freedom to seek, receive, and impart information and opinions of any kind in any form.
>
> **23 Rights of persons arrested or detained**
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> …
>
> (5) Everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person.

High Court judgment

[63] The Judge accepted the respondents' submission that the only difference between an established and well-understood practice and a written policy relates to the question of accessibility. That in turn can affect whether a limit on a right meets the

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[18] At [415]–[416].

requirement of being "prescribed by law" under s 5 of NZBORA. The Judge considered that the important point was that the evidence demonstrated that the policy was soundly based, well-understood and consistently applied. Although a written policy might be desirable, there was no legal obligation to have one.[19]

[64] The Judge considered that it was untenable to suggest that preventing intimate relationships in the circumstances of the plaintiffs' detention amounted to torture or cruel, degrading or disproportionately severe treatment in breach of s 9 of NZBORA. So far as s 23(5) was concerned, the Judge considered that the proposition that humanity and dignity require that patients be permitted to form intimate relationships runs counter to the respondents' clear duty under that section to take reasonable steps to ensure that patients are safely detained. The evidence was overwhelming that patients' wellbeing is the driving force behind the "no sex" policy. The obligation to protect the health and safety of care recipients and others is reflected in s 11 of the ID Care and Rehabilitation Act. No specific power to prohibit sexual activity is required. There was no evidence that sexual relationships might have a therapeutic value for people in the plaintiffs' position. Rather, the evidence was overwhelmingly to the effect that permitting such relationships would be highly likely to risk patients' wellbeing and would impede, rather than facilitate, their rehabilitation. In these circumstances there was no inconsistency between the prohibition on sexual activity and the respondents' obligations under s 23(5).[20]

[65] The complaint about lack of adequate sexual education failed on the evidence. The evidence showed that sexual education and relationship education had been a part of all the plaintiffs' rehabilitation and treatment.[21]

[66] One of the complaints advanced at trial was that the respondents failed to make condoms available to the plaintiffs. The Judge considered that the provision of condoms was not a pre-requisite to the plaintiffs' humane detention. It is a rational extension of the "no sex" policy which does not itself breach s 23(5).[22] Nor was there

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19 At [438]–[439].
20 At [435]–[437].
21 At [442].
22 At [443] and [444].

any evidence that failure to provide condoms gave rise to any real risk to detainees' health in a way that would engage s 23(5).[23]

[67] The plaintiffs' complaint that their private sexual activities had been unlawfully interfered with was focused, so far as Mr M was concerned, on alleged limits on masturbating, and records kept in clinical notes of instances in which masturbation was observed.

[68] The Judge considered that s 23(5) protected detainees' interest in a reasonable degree of personal privacy, in order that they may perform intimate personal activities. Masturbation as such is not protected by s 23(5). The evidence was that there was no prohibition on masturbating in private. Masturbation was only stopped when it occurred in public areas. Limitations on masturbating in a shared space were not, in the Judge's view, capable of constituting a breach of s 23(5). Rather, those limits were plainly necessary for maintaining an appropriate therapeutic environment for all patients.[24]

[69] The Judge considered that the existence of records of the plaintiffs' masturbating at various times did not mean their privacy was breached. The evidence made it clear that recording sexual behaviour in a secure mental health or intellectual disability environment occurs for legitimate clinical purposes. It was not possible retrospectively to review the reason for each record of masturbation, and Mr Ellis did not attempt to do so. This aspect of the claim also failed on the evidence.[25]

[70] The Judge concluded:

> [457] By way of summary, no breach of s 9, s 14 or s 23(5) has been made out in relation to sexual matters:
>
> (a) the "no sex" policy in the Units is necessary in order to keep patients (and staff) safe;
>
> (b) the no sex policy is clear and well understood, despite it not being in writing;

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23 At [445]–[447].
24 At [448]–[449].
25 At [450]–[451].

(c) sex and relationship education is offered in the Units when considered clinically necessary. Wider education about relationships and appropriate physical interactions is also given as part of other rehabilitative programmes;

(d) the fact that condoms are not made readily available is a rational extension of the no sex policy and justifiable on that basis;

(e) masturbation in private is neither prohibited nor discouraged in the Units. But patients masturbating in a public area are directed to their own rooms. While masturbation may be recorded when it is observed that is only for clinical or safety reasons; and

(f) the single occasion on which pornography was removed from Mr S's room does not engage s 23(5) and, to the extent it engages (at a low level) with the right to freedom of expression which is protected by s 14 of the NZBORA it was demonstrably justified.

Appellant's argument

[71] Mr Ellis submitted that the absence of a written policy meant the policy was uncertain and not prescribed by law, particularly when aimed at persons with multiple mental impairments.

[72] He also submitted that the Judge failed to consider what lawful power there is to put in place any such policy in respect of detainees held for public protection, not punitive purposes. He submitted that no such power exists. The respondents should be working towards normal sexual relationships for detainees. The goal should be rehabilitation and return to the community.

[73] In response to questions from the Court, Mr Ellis readily acknowledged that sexual relationships with staff would be inappropriate. He accepted that there could be safety issues in relation to fellow inmates, but did not accept that a prohibition on all relationships with other inmates was appropriate. A reasonable accommodation should be found. If A and B say they want a relationship, he asked, why should it not happen? There need to be protections against abuse. But, he submitted, there also needs to be a balance in which ways are found to enable meaningful relationships for people detained for extended periods. Mr Ellis also referred in the course of argument to the possibility of permitting sexual relationships between inmates and sex workers. An absolute prohibition on sexual relationships, he said, reflects a paternalistic approach which is the opposite of what the CRPD seeks to achieve.

[74] No s 14 NZBORA issue in relation to Mr M was raised before us. We need not address that aspect of the High Court decision.

Analysis

[75] We agree with the Judge that the evidence established that the policy prohibiting sexual relationships in the relevant forensic units was clear and well-understood. No witness suggested that there was any uncertainty about the existence or scope of the policy.

[76] We also agree with the Judge that the source of the power to adopt such a policy is found in the authority conferred by the ID Care and Rehabilitation Act to detain care recipients in a relevant facility, coupled with the requirement in s 11 that the exercise of powers under the Act must be guided by the principle that the care recipient should be treated so as to protect the health and safety of the care recipient and of others, and the rights of the care recipient. As the Judge held, the evidence was overwhelmingly to the effect that permitting sexual relationships between patients would be highly likely to risk their well-being and would impede, rather than facilitate, their rehabilitation. As the clinical witnesses explained, the relevant context is a secure unit in which many patients are vulnerable, with a limited understanding of concepts of consent and other people's boundaries. There may also be people with a history of sexual offending and predation. Section 195A of the Crimes Act 1961 provides that it is an offence for a staff member of an institution where a vulnerable adult resides to fail to take reasonable steps to protect that person from a known risk of sexual assault. Health and disability service providers such as the respondent District Health Boards are required to take action to ensure patients are free from harassment and sexual or other exploitation.[26] Against that backdrop, the challenged policy is readily explicable.

[77] As Mr Ellis was inclined to accept in the course of argument, the existence of such a policy does not breach s 23(5) of NZBORA, let alone s 9. Rather, he suggested,

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[26] Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch cl 2 right 2.

the lawfulness of the policy should be subject to a careful review on ordinary public law principles.

[78] We agree with the Judge that a written policy on this sensitive issue would be desirable, in the interests of clarity, consistency and accessibility. However there is no legal requirement for the policy to be in writing. In circumstances where the rights protected by ss 9 and 23(5) of NZBORA are not limited by the policy, no question arises as to whether such limits are prescribed by law for the purposes of s 5 of NZBORA.

[79] There is some force in Mr Ellis' rhetorical question asking why, if patients A and B say they want a relationship, that should not happen. A policy of the kind adopted by the respondents should be capable of being departed from in some scenarios: for example, where there is evidence of a clear and sustained desire for a relationship, the individuals concerned have the capacity to enter into such a relationship, and the relationship can be accommodated in the facility in which the patients are detained.[27] But these are not issues that arise on the facts of the present case, and it would be inappropriate for the Court to embark on a theoretical consideration of such possibilities. Rather, it is sufficient for us to confirm that the adoption of a policy along these lines is lawful, while noting that if circumstances occur in which a departure from the policy may be appropriate, it would be necessary for those responsible for the detention of the relevant patients to consider the possibility of a case-specific departure from the policy.[28]

[80] The issues of sexual and relationship education, and proactive provision of condoms, were not developed in Mr Ellis' written or oral submissions. The Judge's analysis of these issues is persuasive, and no reason for departing from it was suggested to us. We need say no more about these points.

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[27] See Anita Miller "Sex and Marriage" in Iris Reuvecamp and John Dawson (eds) *Mental Capacity Law in New Zealand* (Thompson Reuters, Wellington, 2019) 237. On capacity to enter into sexual relationships, and the relevance of the individual's ability to understand the need for the other person to consent to sexual relations, see *A Local Authority v JB* [2020] EWCA Civ 735, [2020] WLR(D) 336.

[28] *Practical Shooting Institute (NZ) Inc v Commissioner of Police* [1992] 1 NZLR 709 (HC); and *Financial Services Complaints Ltd v Chief Ombudsman* [2018] NZCA 27, [2018] 2 NZLR 884.

[81] Similarly, no submissions were made to us about the issue of limits on masturbation, or references to certain incidents of masturbation being recorded in clinical notes. The Judge found that this aspect of the claim must fail on the evidence. Mr Ellis did not engage with this finding, or identify any evidence to different effect. In those circumstances, this limb of the appeal cannot succeed.

[82] The issue of inmates engaging in sexual activity with sex workers simply does not arise on the facts in this case. It is a potentially complex topic, which it would be inappropriate for us to embark on in the abstract.

[83] In summary, we agree with the Judge's conclusion that no breach of ss 9 or 23(5) of NZBORA has been made out in relation to sexual matters. Nor has it been established that the "no sex" policy is unlawful by reference to general public law principles.

Fourth ground of appeal — guidelines under MH Assessment and Treatment Act and ID Care and Rehabilitation Act

The issue

[84] In the High Court the plaintiffs advanced a wide-ranging challenge to the use of seclusion and restraint, including "night safety procedures", as a breach of ss 9 and 23(5) of NZBORA. That challenge was unsuccessful, and has not been pursued before us.

[85] However in the course of the hearing, the plaintiffs amended their statement of claim to allege specific illegality arising by virtue of:

(a) the absence of guidelines relating to seclusion under s 148 of the ID Care and Rehabilitation Act; and

(b) the promulgation of guidelines by the Director of Mental Health under s 130 of the MH Assessment and Treatment Act when either:

(i) the power to issue such guidelines, which is conferred on the Director-General of Health, had not been formally delegated; and/or

(ii) any delegation of that power would be unlawful.

[86] The notice of appeal raises the issue of guidelines under s 130 of the MH Assessment and Treatment Act and, at least implicitly, s 148 of the ID Care and Rehabilitation Act. Those issues are addressed below.

High Court judgment

[87] It was common ground before the High Court that s 148 of the ID Care and Rehabilitation Act requires guidelines in relation to seclusion to be issued by the Director-General of Health. It was also common ground that despite that mandatory provision, no such guidelines had been issued.

[88] However the Judge considered that it was not necessary to make a declaration in relation to the absence of the required guidelines, as the question of seclusion under the ID Care and Rehabilitation Act did not arise on the facts of this case. Only one of the plaintiffs, Mr M, was ever subject to the ID Care and Rehabilitation Act. Shortly before he became a care recipient under that Act, he self-harmed while in seclusion and from that point in time he was no longer secluded. The Judge also noted that procedures ensuring safety during an episode of seclusion, which reflect and expand on the guidance issued for MH Assessment and Treatment Act seclusion, were in place at each facility at all times.[29]

[89] Guidelines were issued about the use of seclusion before, and shortly after, the MH Assessment and Treatment Act came into force. The Ministry's 1992 *Procedural Guidelines for the Use of Seclusion* (1992 Guidelines) were first issued in June 1992, before the MH Assessment and Treatment Act came into force, and again in December 1992, after the Act came into force. The Judge noted that these guidelines

[29] High Court judgment, above n 2, at [607]–[608].

appeared to have been signed off by the Director of Mental Health, in the sense that the "Foreword" had his name and designation at the bottom.[30]

[90] Section 130 of the MH Assessment and Treatment Act provides:

> **130 Director-General may promulgate standards**
>
> The Director-General of Health may from time to time issue—
>
> (a) guidelines for the purposes of this Act; and
>
> (b) standards of care and treatment of patients.

[91] In the High Court the plaintiffs challenged the 1992 Guidelines on the basis that they had not been issued by the Director-General of Health personally, and there was no evidence that the Director-General had delegated the power to issue such guidelines to the Director of Mental Health. Even assuming the power could be delegated, no instrument of delegation had been located by the respondents.

[92] The Judge considered that this challenge was misconceived. Statutory authority is not required for the issue of guidelines. Both before and after the enactment of the MH Assessment and Treatment Act, it was open to the Director of Mental Health to issue such guidelines. Consistent with that proposition, the Judge noted, the 1992 Guidelines do not refer to s 130 of the MH Assessment and Treatment Act.[31]

Appellant's argument

[93] Mr Ellis reiterated the arguments presented before the High Court. This issue was not at the forefront of his argument, and was addressed only briefly in his written and oral submissions.

Analysis — s 148 ID Care and Rehabilitation Act

[94] Section 148 of the ID Care and Rehabilitation Act requires the Director-General of Health to issue guidelines in relation to seclusion. It is surprising

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30 At [610].
31 At [614].

that no guidelines have been issued under that Act since it came into force in 2004. We anticipate that now that this omission has been highlighted, the Director-General of Health will issue the required guidelines in the near future, if indeed this has not already happened since the hearing of the appeal.

[95] However we agree with the Judge that it would be inappropriate to make a formal declaration about the absence of s 148 guidelines in a case in which no issue about such guidelines arises on the facts. The absence of such guidelines has had no practical implications for Mr M, and there has been no incursion on his rights that requires the vindication of a declaration.

Analysis — s 130 MH Assessment and Treatment Act

[96] We agree with the Judge that the issue of guidelines did not require statutory authority either before or after the MH Assessment and Treatment Act came into force. Section 130 is not the only available source of such a power: the responsibility of the Director of Mental Health for the provision of mental health services in secure facilities carries with it the ability to issue guidelines in relation to the provision of care in those facilities. In these circumstances, the question of delegation of the power to issue guidelines under s 130 is a red herring.

Fifth ground of appeal — discrimination and arbitrary detention

The issues

[97] We repeat, for ease of reference, the background facts relevant to this ground of appeal. As noted above, in 2001 Mr M was charged with assault with intent to rob. He was found to be under disability pursuant to s 115(1)(a) of the CJA. On 20 December 2001 he was ordered to be detained as a special patient under the MH Assessment and Treatment Act. His status as a special patient continued under the MH Assessment and Treatment Act until he became a special care recipient under the ID Care and Rehabilitation Act in July 2007.

[98] Because Mr M was initially detained as a special patient, the charges against him did not go to trial. Those charges remained outstanding. He was required to

remain detained in a hospital while he received treatment. Every six months the responsible clinician was required to review his mental impairment (under s 76 of the MH Assessment and Treatment Act, then under s 77 of the ID Care and Rehabilitation Act) and issue a certificate setting out their findings. On the expiry of half the maximum sentence for his index offence, on 20 December 2008, he continued to be assessed as unfit to stand trial. On 14 January 2009 the Attorney-General gave a direction under s 31(4) of the MI Criminal Procedure Act that he be detained as a care recipient. That direction was deemed to be a compulsory care order for the purposes of the ID Care and Rehabilitation Act, and the provisions of that Act in relation to such orders applied to his detention under that Act, including s 77 requiring regular clinical reviews of his condition. His status as a care recipient under the ID Care and Rehabilitation Act continued until December 2013. He received secure care until December 2012, and supervised care from December 2012 to December 2013.

[99] Mr Ellis submitted that Mr M's treatment under the applicable legislation was discriminatory because he was deprived, by reason of his disability, of the opportunity to plead not guilty to the charge of assault with intent to rob, and have his guilt determined at a trial. He submitted that Mr M's detention under the applicable legislation was also discriminatory because the detention was indefinite, and in his case substantially exceeded what could have been imposed by way of punishment on conviction.

[100] Mr Ellis also submitted that Mr M's detention was arbitrary, in breach of s 22 of NZBORA. In particular, he argued that Mr M's detention became arbitrary in December 2008 when the period of half the maximum sentence for the relevant offence had expired, and there was a gap of some three weeks before the Attorney-General issued a direction under s 31(4) of the MI Criminal Procedure Act that Mr M be detained as a care recipient. He submitted that the direction given by the Attorney-General under s 31(4) of the MI Criminal Procedure Act in January 2009 that Mr M was to continue to be held as a care recipient was an unlawful act of Executive detention and was made in breach of natural justice.

[101] Mr Ellis also submitted that the system of clinical review under s 76 of the MH Assessment and Treatment Act resulted in an arbitrary detention: that issue is addressed separately below as the sixth ground of appeal.

[102] In the High Court Mr M's discrimination claim appears to have been presented by reference to the provisions governing initial and continued detention under the MI Criminal Procedure Act, which was enacted in 2003 and came into force on 1 September 2004. Mr M was in fact initially detained pursuant to an order under the CJA. But the claim was presented at a level of generality that renders the differences between the two regimes immaterial. We will follow the approach adopted in the High Court judgment of referring solely to the provisions of the MI Criminal Procedure Act governing detention of mentally impaired defendants, rather than referring to provisions of the (now repealed) CJA, when considering this ground of appeal.

[103] We begin by addressing the discrimination claim. We then address the argument that Mr M's detention became arbitrary in December 2008 when the period of half the maximum sentence for the relevant offence expired.

High Court judgment — discrimination

[104] Section 19 of NZBORA provides:

> **19 Freedom from discrimination**
>
> (1) Everyone has the right to freedom from discrimination on the grounds of discrimination in the Human Rights Act 1993.
>
> (2) Measures taken in good faith for the purpose of assisting or advancing persons or groups of persons disadvantaged because of discrimination that is unlawful by virtue of Part 2 of the Human Rights Act 1993 do not constitute discrimination.

[105] The prohibited grounds of discrimination under the Human Rights Act 1993 include disability, which is defined to include intellectual or psychological disability or impairment.[32]

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[32] Human Rights Act 1993, s 21(1)(h).

[106] The Judge applied the test for discrimination in the context of s 19 of NZBORA set out in this Court's decision in *Ministry of Health v Atkinson*:[33]

> … the first step in the analysis under s 19 is to ask whether there is differential treatment or effects as between persons or groups in analogous or comparable situations on the basis of a prohibited ground of discrimination. The second step is directed to whether that treatment has a discriminatory impact.

[107] The Judge noted that for differential treatment to have a discriminatory impact, it must result in material disadvantage.[34] The Judge considered that the proposition that it is disability which forms the basis under the MI Criminal Procedure Act for people in Mr M's situation being treated differently from "ordinary offenders" was highly questionable. The reason for the differential treatment was risk, not mental health status. The Judge considered that the proposition that "ordinary offenders" are the appropriate comparator group was also problematic.[35] That view, she said, found high level support from the decision of the Canadian Supreme Court in *Winko v British Columbia (Forensic Psychiatric Institute)*.[36]

[108] The Judge also considered that the decision in *Winko* confirms that a regime such as that which is established by the MI Criminal Procedure Act advantages rather than disadvantages those who are subject to it. She did not consider that special patients or special care recipients are disadvantaged as a result of their qualifying disability, as:[37]

> (a) detention in each case commences with a judicial order;
>
> (b) those unfit to stand trial are not convicted of any offence;
>
> (c) there is no minimum period of detention before release can occur;
>
> (d) the need for continuing detention is reviewed more regularly;
>
> (e) the reviews for both groups are undertaken by appropriately expert people and bodies;

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33 *Ministry of Health v Atkinson* [2012] NZCA 184, [2012] 3 NZLR 456 at [55] (footnote omitted).
34 High Court Judgment, above n 2, at [674], referring to *Ministry of Health v Atkinson*, above n 33, at [109].
35 High Court judgment, above n 2, at [679]–[680].
36 *Winko v British Columbia (Forensic Psychiatric Institute)* [1999] 2 SCR 625.
37 High Court judgment, above n 2, at [683].

(f) every assessment of the need for continued detention is automatically referred to District Inspectors, who can support patients to challenge that assessment;

(g) there are rights of appeal in relation to an assessment with access to legal advice and representation at all stages; and

(h) Courts can conduct inquiries into a patient's continued detention, either on application or on their own motion.

[109] The discrimination claim was therefore not made out.

Appellant's argument in relation to discrimination

[110] Mr Ellis' argument on this aspect of the appeal was grounded on arts 5, 13 and 14 of the CRPD; the approach of the United Nations Committee on the Rights of Persons with Disabilities (CRPD Committee) set out in *Noble v Australia*;[38] and the CRPD Committee's Guidelines on art 14 of the CRPD.[39] In essence, the simple but stark argument advanced before us was that Mr M's disability was the reason he was deprived of the opportunity to have the allegations against him tested at a trial at which he could plead not guilty. It was also the reason for his detention on a basis that was significantly differently from, and longer than, the period of detention to which a person who had committed the offences with which he was charged would have been exposed. Mr Ellis submitted that the existence of a different stream of legal process for the mentally impaired is inherently discriminatory and inconsistent with the CRPD, and with s 19 of NZBORA. The specific challenges Mr Ellis advanced to aspects of the treatment of Mr M were all premised on that starting point.

[111] Articles 5, 13 and 14 of the CRPD provide as follows:

Article 5
Equality and non-discrimination

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

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38 *Noble v Australia* (2016) CRPD/C/16/D/7/2012.

39 *Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities* (September 2015) [CRPD Committee Guidelines].

3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.

4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

Article 13
Access to justice

1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

Article 14
Liberty and security of person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

(*a*) Enjoy the right to liberty and security of person;

(*b*) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.

[112] In *Noble v Australia* the CRPD Committee upheld a challenge to the Western Australian legislation in relation to mentally impaired defendants. The CRPD Committee said:

> 8.3 The Committee recalls that under article 5 (1) and (2) of the Convention, States parties must ensure that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law, and must take all appropriate steps to ensure that reasonable accommodation is provided to promote equality and eliminate discrimination. The Committee also recalls that discrimination can result from the discriminatory effect of a rule or measure that is not intended to discriminate, but that disproportionately affects persons with disabilities. In the present case, the Committee notes that the Mentally Impaired

Defendants Act is intended to address the situation of persons with psychosocial and intellectual impairments who are found unfit to stand trial on the basis of mental impairment. The issue before the Committee is therefore to assess whether the differential treatment provided under the Act is reasonable or whether it results in discriminatory treatment of persons with disabilities.

8.4 … As a result of the application of the [Criminal Law (Mentally Impaired Defendants) Act 1996 (WA) (MID Act)], the author's rights to a fair trial were instead fully suspended, depriving him of the protection and equal benefit of the law. The Committee therefore considers that the [MID Act] resulted in a discriminatory treatment of the author's case, in violation of article 5 (1) and (2) of the Convention.

…

8.6 … The Committee considers that while States parties have a certain margin of appreciation to determine the procedural arrangements to enable persons with disabilities to exercise their legal capacity, the relevant rights of the person concerned must be respected. That did not happen in the author's case, as he had no possibility and was not provided with adequate support or accommodation to exercise his rights to access to justice and a fair trial. In view thereof, the Committee considers that the situation under review amounts to a violation of the author's rights under articles 12 (2) and (3) and 13 (1) of the Convention.

8.7 … The author's detention was therefore decided on the basis of the assessment by the State party's authorities of potential consequences of his intellectual disability, in the absence of any criminal conviction, thereby converting his disability into the core cause of his detention. The Committee therefore considers that the author's detention amounted to a violation of article 14 (1) (b) of the Convention according to which "the existence of a disability shall in no case justify a deprivation of liberty".

(Footnotes omitted).

[113] The Committee's Guidelines on art 14, issued in September 2015, include the following relevant passages:

III. The absolute prohibition of detention on the basis of impairment

6. There are still practices in which States parties allow for the deprivation of liberty on the grounds of actual or perceived impairment. In this regard the Committee has established that article 14 does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived impairment. However, legislation of several States parties, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived impairment, provided there are other reasons for their detention, including that they are deemed dangerous to themselves or others. This practice is incompatible with article 14; it is discriminatory in nature and amounts to arbitrary deprivation of liberty.

7. During the negotiations of the Ad Hoc Committee leading up to the adoption of the Convention there were extensive discussions on the need to include a qualifier, such as "solely" or "exclusively", in the prohibition of deprivation of liberty due to the existence of an actual or perceived impairment in the draft text of article 14(1)(b). States opposed it, arguing that it could lead to misinterpretation and allow deprivation of liberty on the basis of their actual or perceived impairment in conjunction with other conditions, like danger to self or others. Furthermore, discussions were held on whether to include a provision for periodic review of the deprivation of liberty in the text of draft article 14(2). Civil society also opposed the use of qualifiers and the periodic review approach. Consequently, article 14(1)(b) prohibits the deprivation of liberty on the basis of actual or perceived impairment even if additional factors or criteria are also used to justify the deprivation of liberty. The issue was settled in the seventh meeting of the Ad Hoc Committee.

…

IV. Involuntary or non-consensual commitment in mental health institutions

10. Involuntary commitment of persons with disabilities on health care grounds contradicts the absolute ban on deprivation of liberty on the basis of impairment (article 14(1)(b)) and the principle of free and informed consent of the person concerned for health care (article 25). The Committee has repeatedly stated that States parties should repeal provisions which allow for the involuntary commitment of persons with disabilities in mental health institutions based on actual or perceived impairments. Involuntary commitment in mental health facilities carries with it the denial of the person's legal capacity to decide about care, treatment and admission to a hospital or institution, and therefore violates article 12 in conjunction with article 14.

…

VII. Deprivation of liberty on the basis of perceived danger allegedly posed by persons with disabilities, alleged need for care or treatment, or any other reasons

13. Throughout all the reviews of State party reports, the Committee has established that it is contrary to article 14 to allow for the detention of persons with disabilities based on the perceived danger of persons to themselves or to others. The involuntary detention of persons with disabilities based on risk or dangerousness, alleged need for care or treatment or other reasons tied to impairment or health diagnosis, such as severity of impairment, or for the purpose of observation, is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty.

14. Persons with intellectual or psychosocial impairments are frequently considered dangerous to themselves and others when they do not consent and/or resist medical or therapeutic treatment. All persons, including those with disabilities, have a duty to do no harm. Legal systems based on the rule of law have criminal and other laws in place to deal with breaches of this obligation. Persons with disabilities are frequently denied equal protection under these laws by being diverted to a separate track of law, including through mental health laws. These laws and procedures commonly have a lower standard when it comes to human rights protection, particularly the

> right to due process and fair trial, and are incompatible with article 13, in conjunction with article 14, of the Convention.
>
> …
>
> **VIII. Detention of persons unfit to stand trial in criminal justice systems and/or incapable of criminal liability**
>
> 16. The Committee has established that declarations of unfitness to stand trial or incapacity to be found criminally responsible in criminal justice systems and the detention of persons based on those declarations, are contrary to article 14 of the Convention since it deprives the person of his or her right to due process and safeguards that are applicable to every defendant. The Committee has also called for States parties to remove those declarations from the criminal justice system. The Committee has recommended that "all persons with disabilities who have been accused of crimes and… detained in jails and institutions, without trial, are allowed to defend themselves against criminal charges, and are provided with required support and accommodation to facilitate their effective participation", as well as procedural accommodations to ensure fair trial and due process.
>
> (Footnotes omitted).

[114] Mr Ellis frankly acknowledged that the CRPD Committee's view that the involuntary detention of persons with disabilities based on risk or dangerousness is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty, is controversial. The United Nations Human Rights Committee does not share the view of the CRPD Committee on this issue. In December 2014 the United Nations Human Rights Committee published its General Comment No. 35 on art 9, which reads:[40]

> The existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others. It must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law.

Analysis — discrimination claim

[115] The discrimination claim pleaded in the High Court did not refer to the ID Care and Rehabilitation Act or seek declarations in relation to the separate regime for mentally impaired defendants under the MI Criminal Procedure Act taken as a whole.

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[40] *General comment No. 35 Article 9 (Liberty and security of person)* UN Doc CCPR/C/GC/35, 16 December 2014, at [19] (footnotes omitted). See also *A v New Zealand* Communication No. 754/97, UN Doc CCPR/C/66/D/754/1997 (3 August 1999); and *Fijalkowska v Poland* Communication No. 1061/2002, UN Doc CCPR/C/84/D/1061/2002 (26 July 2005).

The relevant cause of action sought relief in relation to three specific provisions: r 4.30 of the High Court Rules, s 31(4) of the MI Criminal Procedure Act and s 76 of the MH Assessment and Treatment Act.[41] But as we noted above, the starting point for Mr Ellis' argument was the more general proposition that the existence of a separate procedural regime for mentally impaired defendants was inherently discriminatory, in breach of s 19 of NZBORA. Against that backdrop he argued that specific aspects of the MI Criminal Procedure Act and the MH Assessment and Treatment Act were discriminatory and inconsistent with s 19. There was something of a disconnect between the claim as pleaded, focusing as it did on r 4.30 of the High Court Rules and two specific statutory provisions, and the broader argument advanced before us on appeal. The explanation may be that the pleading was framed in light of this Court's previous rejection in *Ruka v R* of an argument that the MI Criminal Procedure Act as a whole was inconsistent with s 19 of NZBORA.[42] However that did not deter Mr Ellis from pursuing his more general argument before us. Despite the disconnect with the pleading, and despite the difficulty the argument faces in light of this Court's decision in *Ruka*, we will begin by addressing the general proposition that underpinned the more specific issues raised: the challenge to the existence of a separate procedural regime for mentally impaired defendants as inherently discriminatory, in breach of s 19 of NZBORA.

[116] The argument presented to us ran together two different but related respects in which Mr M's treatment was said to be discriminatory: denial of an opportunity to plead not guilty and have the charges determined at a trial, and detention on a different basis and (potentially) for a longer period than an accused found guilty of the relevant offence. In order to avoid confusion, it is necessary to address separately each of these two features of the procedural regime that applied to Mr M.

[117] We agree with the Judge that the starting point for assessing claims of discrimination under s 19 of NZBORA is the well-established test set out in *Ministry of Health v Atkinson*. As Mr Ellis submits, under the MI Criminal Procedure Act provisions governing fitness to plead mentally impaired defendants are treated

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41 The pleading refers throughout to s 31(4) of the Mental Health (Compulsory Assessment and Treatment) Act 1992, but this appears to be a mistake.

42 *Ruka v R* [2011] NZCA 404, (2011) 25 CRNZ 768.

differently from defendants who are not mentally impaired. For the purposes of that Act the phrase "unfit to stand trial":[43]

> (a) means a defendant who is unable, due to mental impairment, to conduct a defence or to instruct counsel to do so; and
>
> (b) includes a defendant who, due to mental impairment, is unable—
>
> (i) to plead:
>
> (ii) to adequately understand the nature or purpose or possible consequences of the proceedings:
>
> (iii) to communicate adequately with counsel for the purposes of conducting a defence.

[118] We accept that when examining the complaint that Mr M was denied the opportunity to plead guilty and go to trial because of his intellectual disability, the relevant comparator group is the group of defendants who are not mentally impaired. The two groups are treated differently under the MI Criminal Procedure Act: a finding that a defendant is unfit to stand trial under sub-pt 1 of pt 2 of the MI Criminal Procedure Act is the direct result of a finding in relation to that defendant's mental impairment.

[119] So the question becomes whether a finding made before trial that a defendant is unfit to stand trial imposes a material disadvantage on a defendant, compared with the group of defendants who are not mentally impaired and who stand trial in the normal way. A trial may result in a defendant's acquittal, or in their conviction and the imposition of an appropriate sentence under the Sentencing Act 2002. In order to assess whether the separate regime for defendants who are unfit to stand trial imposes a material disadvantage on those defendants, we must describe that regime in a little more detail.

[120] Following a finding that a defendant is unfit to stand trial, the court inquires into the defendant's involvement in the offence. The court must decide whether it is satisfied, on the balance of probabilities, that the evidence against the defendant is sufficient to establish that the defendant caused the act or omission that forms the basis

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[43] Criminal Procedure (Mentally Impaired Persons) Act 2003, s 4.

of the offence with which the person is charged.[44] If the court is not so satisfied, it must dismiss the charge. The finding that the defendant is unfit to stand trial is deemed to have been quashed.[45] If the court is satisfied that this test is met, then it must deal with the defendant under sub-pt 3 of pt 2 of the MI Criminal Procedure Act. Under sub-pt 3 the court must order that inquiries be made to determine the most suitable method of dealing with the person under ss 24 or 25 of the MI Criminal Procedure.[46] Those provisions read as follows:

> **24 Detention of defendant found unfit to stand trial or insane as special patient or special care recipient**
>
> (1) When the court has sufficient information on the condition of a defendant found unfit to stand trial or acquitted on account of his or her insanity, the court must—
>
> (a) consider all the circumstances of the case; and
>
> (b) consider the evidence of 1 or more health assessors as to whether the detention of the defendant in accordance with one of the orders specified in subsection (2) is necessary; and
>
> (c) make one of the orders referred to in paragraph (b) if it is satisfied that the making of the order is necessary in the interests of the public or any person or class of person who may be affected by the court's decision.
>
> (2) The orders referred to in subsection (1) are that the defendant be detained—
>
> (a) in a hospital as a special patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992; or
>
> (b) in a secure facility as a special care recipient under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
>
> (3) Before the court makes an order specified in subsection (2)(a), the court must have received evidence, under subsection (1)(b), about the defendant from at least 1 health assessor who is a psychiatrist.
>
> **25 Alternative decisions in respect of defendant unfit to stand trial or insane**
>
> (1) If, after considering the matters specified in section 24(1)(a) and (b) concerning a defendant found unfit to stand trial or acquitted on account of his or her insanity, the court is not satisfied that an order

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44 Section 10. See also ss 11 and 12.
45 Section 13(2).
46 Section 23(1).

under section 24(2) is necessary, the court must deal with the defendant—

(a) by ordering that the defendant be treated as a patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992; or

(b) by ordering that the defendant be cared for as a care recipient under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003; or

(c) if the person is liable to be detained under a sentence of imprisonment, by deciding not to make an order; or

(d) by ordering the immediate release of the defendant.

(2) Before the court makes an order under subsection (1)(a), the court must be satisfied on the evidence of 1 or more health assessors (at least 1 of whom must be a psychiatrist) that the defendant is mentally disordered.

(3) Before the court makes an order under subsection (1)(b), the court must be satisfied on the evidence of 1 or more health assessors that the defendant—

(a) has an intellectual disability; and

(b) has been assessed under Part 3 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003; and

(c) is to receive care under a care programme completed under section 26 of that Act.

(4) In the exercise of its powers under subsection (1), the court may take into account any undertaking given by, or on behalf of, the defendant that the defendant will undergo or continue to undergo a particular programme or course of treatment.

[121] An order that the defendant be detained as a special patient under the MH Assessment and Treatment Act or as a special care recipient under the ID Care and Rehabilitation Act may be made only where the court is satisfied that such an order is necessary. The test of necessity sets a high threshold.[47] Detention under this regime is not imposed for a punitive purpose: if it is imposed, it is for the purpose of public protection in circumstances where no other disposition is sufficient to achieve that objective.

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47 *M (CA819/11) v R* [2012] NZCA 142, (2012) 28 FRNZ 773 at [17].

[122] The continuing need for detention on this basis is regularly reviewed, at least every six months. If the person ceases to be unfit to stand trial, then the Attorney-General must either direct that they be brought before the relevant court for trial, or direct that they be held as a patient or care recipient.[48] If they remain unfit to stand trial, but detention under s 24 ceases to be necessary, a direction must be given that they be held as a patient or care recipient.[49] As noted above, such a direction must also be given once the period of half the maximum sentence for the index offence expires.[50]

[123] A person held as a care recipient under the ID Care and Rehabilitation Act pursuant to a direction given by the Attorney-General may be detained in a secure facility pursuant to a compulsory care order only if a Family Court Judge is satisfied that supervised care would pose a serious danger to the health or safety of the care recipient or of others, and directs that the care recipient receive secure care.[51] Detention in a secure facility is not a necessary consequence of care recipient status. The condition of every care recipient who is subject to a court order is reviewed at least six monthly.[52] The care recipient's compulsory care coordinator may apply to the Family Court for extension of a compulsory care order.[53] The need for secure care must be reviewed on each occasion on which extension of a compulsory care order is sought.[54] The principles governing extension decisions were considered by a Full Court of this Court in *RIDCA Central v VM*.[55] The Court held that the liberty interest of the care recipient must be taken into account in determining whether to extend a compulsory care order. An extension decision requires ongoing and increasing justification the longer a care recipient has been subject to a compulsory care order, because the community protection interest will need to be greater to outweigh the increased weight given to the liberty interest of the care recipient.[56]

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48 MI Criminal Procedure Act, s 31(2).
49 Section 31(3).
50 Section 31(4).
51 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 85(3).
52 Section 77.
53 Section 85.
54 Section 85(2).
55 *RIDCA Central (Regional Intellectual Disability Care Agency) v VM* [2011] NZCA 659, [2012] 1 NZLR 641.
56 At [90]–[91].

[124] There is a similar but not identical regime for a person who is directed to be held as a patient under the MH Assessment and Treatment Act at the expiry of the period of half the relevant maximum sentence, under s 31(4) of the MI Criminal Procedure Act. But we need not discuss that regime, as it never applied to Mr M.

[125] We do not consider that a defendant who is subject to this procedural regime, rather than the standard criminal justice regime, is at a material disadvantage. This regime has significant advantages for the defendant, as the Judge noted.[57] They are not exposed to the risk of a conviction and sentence. They will not be detained unless detention is necessary in the public interest, and if they are detained that detention will be frequently reviewed and will continue only for so long as it remains necessary in the public interest. A detention on this basis is not intended as a punishment: rather, it is a public safety measure. The disadvantages of being subject to this regime identified by Mr Ellis relate to the potential for detention — including, as in Mr M's case, lengthy detention. But that is not a necessary consequence of being subject to the separate regime. Any detention results from separate and subsequent decisions that can be, and should be, separately assessed for NZBORA compliance.

[126] As will be apparent from this analysis, we do not accept that the New Zealand procedural regime for identifying defendants who are unfit to stand trial, and dealing with those defendants outside the normal criminal justice system, involves a denial of due process or of other relevant safeguards. The CRPD Committee's Guidelines suggest that such regimes will invariably involve a denial of a fair process and relevant safeguards.[58] But it seems to us that the specific features of a national regime must be examined to ascertain whether a disadvantage of this kind exists simply by virtue of being subject to the separate regime. The New Zealand regime is very different from the Western Australian regime considered in *Noble v Australia*: it provides procedural and substantive protections that were absent in that case. In particular, the New Zealand regime does not lead inexorably to detention, and can never result in detention in a prison. If the CRPD Committee is suggesting in its Guidelines that any difference in procedural regimes as between intellectually disabled defendants and other defendants is necessarily discriminatory, we do not accept that that is the position

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57 High Court judgment, above n 2, at [683].
58 CRPD Committee Guidelines, above n 39, at [16].

under s 19 of NZBORA. In particular, we do not accept that reading s 19 in light of the CRPD requires the court to adopt an approach different from that outlined in *Atkinson*. A context-specific inquiry into whether there is a material disadvantage remains necessary.

[127] Had we considered that there was a material disadvantage, we would have wanted to hear argument about whether that disadvantage was justified under s 5 of NZBORA before reaching a view on whether the MI Criminal Procedure regime was inconsistent with NZBORA. But the way the case was presented meant that this question was not addressed before us. There was no pleading that the MI Criminal Procedure Act was inconsistent with NZBORA; the relief sought did not include any declaration to that effect; and Mr Ellis did not invite the Court to depart from its previous decision in *Ruka*. Indeed he did not even refer to that decision in his submissions. In those circumstances, we think it is sufficient to say that on the basis of the argument presented to us we have not been persuaded that the entire regime is discriminatory. We do not accept that that should be our starting point when considering the more specific challenges that were pleaded and pursued in the High Court, and which are live on this appeal.

[128] We return to the statutory provisions that provide for detention of a person who is unfit to stand trial, and in particular s 31(4) of the MI Criminal Procedure Act. As we said, detention under this regime is not intended as a punitive measure: the purpose it serves is public safety (or, under the provisions that apply to care recipients, protection of the health and safety of the care recipient). Detention under the MI Criminal Procedure Act and the ID Care and Rehabilitation Act is not indefinite.[59] Rather, detention is ordered for finite periods and can be extended under the ID Care and Rehabilitation Act only if the court considers it is necessary in the public interest. A strict necessity test applies to the initial order, and to extension decisions. If and when the risk that justified the detention is no longer present, the detention must come to an end. The care recipient's liberty interest must be given increasing weight as time passes. There are rights of review and rights of appeal. The regime meets all the

[59] A compulsory treatment order made under s 34(4) of the MH Assessment and Treatment Act may be indefinite: but that provision never applied to Mr M so is not relevant here.

criteria identified by the United Nations Human Rights Committee in General Comment No. 35, set out at [114] above.

[129] We agree with the Judge that the argument that "ordinary offenders" are the appropriate comparator group when assessing whether this detention regime is discriminatory is problematic. The purpose of the MI Criminal Procedure Act or ID Care and Rehabilitation Act detention regime is different from the purpose of the standard criminal justice regime. The critical element of risk to public safety is not squarely in the frame if "ordinary offenders" are chosen as the comparator group. One possible approach might be to narrow down the comparator group to offenders who pose a significant risk to public safety, and whose detention is necessary in the public interest: the comparison would then take into account the potential for the offender to be denied parole, to be subject to a sentence of preventive detention, to be subject to an extended supervision order, and other mechanisms for addressing the risk posed by such offenders. Another possible approach would be to look to other groups outside the criminal justice system that pose risks to public health and safety — for example, individuals who are suffering from a serious contagious disease — and the circumstances in which the law provides for their detention. But no analysis along these lines was developed before us.

[130] The pleaded challenge to s 31(4) of the MI Criminal Procedure Act faces the additional difficulty that a direction under s 31(4) that a person be held as a care recipient under the ID Care and Rehabilitation Act may result in the person receiving either secure care in a secure facility, or supervised care which is provided in a community facility. It is especially difficult to identify a relevant comparator group in the context of s 31(4).

[131] If a relevant comparator group had been identified, and if we had been persuaded that individuals with intellectual disabilities were treated differently and materially disadvantageously, once again we would have wanted to hear argument about whether that disadvantage was justified under s 5 of NZBORA. That issue was not addressed before us.

[132] In summary, on the basis of the very general argument presented by Mr Ellis we are not persuaded that the decisions made about Mr M's detention, and in particular the direction given under s 31(4) of the MI Criminal Procedure Act, were discriminatory in breach of s 19 of NZBORA.

High Court judgment — arbitrary detention

[133] The duration of a person's detention as a special patient or special care recipient where a person is unfit to stand trial is governed by ss 30 and 31 of the MI Criminal Procedure Act:

> **30 Duration of detention as special patient or special care recipient where person unfit to stand trial**
>
> (1) The maximum period for which a defendant who has been found unfit to stand trial can be detained under section 24 as a special patient or a special care recipient is—
>
> (a) 10 years from the date of the making of the order under section 24 if the defendant was charged with an offence that was punishable by imprisonment for life; or
>
> (b) if paragraph (a) does not apply, a period from the date of the order under section 24 equal to half the maximum term of imprisonment to which the defendant would have been liable if he or she had been convicted of the offence charged.
>
> (2) If the defendant was charged with more than 1 offence, the relevant offence for the purposes of subsection (1)(b) is the offence punishable by the longest term of imprisonment.
>
> (3) An order under section 24 in respect of a defendant who has been found unfit to stand trial continues in force during the maximum period specified in subsection (1) until—
>
> (a) the defendant is brought before a court in accordance with a direction given under section 31; or
>
> (b) a direction is given, under section 31, that the defendant be held as a patient or as a care recipient.
>
> (4) Subsection (3) is subject to sections 84 and 128 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 or to section 105 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, as the case may require.
>
> (5) An order under section 24 is to be treated as cancelled if every charge brought against the defendant in the proceedings in which the order was made is withdrawn or dismissed.

31 Change of status from special patient to patient or special care recipient to care recipient where person unfit to stand trial

(1) This section applies to a defendant who has been found unfit to stand trial and who is detained as a special patient or as a special care recipient in accordance with an order under section 24 (the **defendant**).

(2) If, before or on the expiry of the relevant maximum period specified in section 30, a certificate is given under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 to the effect that the defendant is no longer unfit to stand trial, the Attorney-General must either—

(a) direct that the defendant be brought before the appropriate court; or

(b) direct that the defendant be held as a patient or, as the case requires, as a care recipient.

(3) If, at any time before the expiry of the relevant maximum period specified in section 30, a certificate is given under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 to the effect that, although the defendant is still unfit to stand trial, the continued detention of the defendant under section 24 is no longer necessary, the Minister of Health, acting with the concurrence of the Attorney-General, must—

(a) consider whether, in the Minister's opinion, the continued detention of the defendant under that section is no longer necessary; and

(b) direct that the defendant be held as a patient or, as the case requires, as a care recipient if, in the Minister's opinion, that detention is no longer necessary.

(4) The Attorney-General must direct that the defendant be held as a patient or, as the case requires, as a care recipient if—

(a) the defendant is still detained as a special patient or as a special care recipient when the maximum period specified in section 30 expires; and

(b) no direction under subsection (2) or subsection (3) has been given in respect of the defendant; and

(c) no certificate of the kind referred to in subsection (2) has been given in respect of the defendant.

(5) A direction under this section—

(a) that the defendant be held as a patient is to be regarded as a compulsory treatment order for the purposes of the Mental

> Health (Compulsory Assessment and Treatment) Act 1992, and the provisions of that Act apply accordingly:
>
> (b) that the defendant be held as a care recipient is to be regarded as a compulsory care order for the purposes of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and the provisions of that Act apply accordingly.
>
> (6) The powers and duties conferred and imposed on the Attorney-General by this section are not capable of being exercised or performed by the Solicitor-General.

[134] Section 32 provides that when a direction is given under s 31 that a defendant be held as a patient or a care recipient, the proceedings in which the defendant was ordered to be detained are stayed. The defendant may not be charged again with an offence with which he or she was charged in those proceedings.

[135] Before the High Court Mr Ellis submitted that:

(a) The period of detention authorised by s 30(3) only continues during the maximum period specified in s 30(1). In this case, that period expired on 20 December 2008 on the expiry of a period equal to half the maximum term of imprisonment to which Mr M would have been liable if convicted. So, Mr Ellis argued, Mr M's detention after that time was not authorised by the legislation. And it was no longer open to the Attorney-General to make a direction for his continuing detention under s 31.

(b) The giving of a s 31(4) direction was an act of Executive detention, contrary to the Petition of Right 1627.

(c) the Attorney-General had failed to comply with the requirements of natural justice before making a s 31(4) direction. Mr M had no opportunity to be heard on whether such a direction should be made.

[136] The Judge did not accept the submission that the effect of s 30(3) was that the order for Mr M's detention expired on 20 December 2008, and could not be extended. The Judge considered that a delay of a few days or even a week or two in making the direction did not mean that the patient is no longer lawfully detained and must be

released from detention. In the absence of clinical certificates of the kind referred to in s 31(2) and (3), the only order that can be made under s 31 is a direction that a special patient becomes a patient, which is deemed to be a compulsory treatment order. None of the s 31 options involves release. It would be wholly inconsistent with that clear legislative direction if a short delay resulted in a default position (release from compulsory status entirely) that was not contemplated by the legislation.[60]

[137] The Judge also did not accept the submission that the s 31(4) direction was detention by an act of the Executive, contrary to the Petition of Right 1627. The Attorney-General's direction is both authorised and required by an Act of Parliament: s 31(4). The Attorney-General has no discretion as to the direction he or she makes if the pre-requisites are established. The direction is deemed to be a compulsory treatment order made by a court, and carries with it all the safeguards that come with such an order.[61]

[138] The Judge also dismissed the argument that the detention was arbitrary because there had been a breach of the requirements of natural justice. The Judge considered that the mandatory nature of the direction meant that no question of natural justice arose. Affording a patient a right to be heard prior to the Attorney-General making the decision required by s 31(4) could make no conceivable difference. Release for those in the position of Mr M was not an option under s 31. That could only occur in accordance with the clinical review procedures under the MH Assessment and Treatment Act.[62]

Appellant's argument — arbitrary detention

[139] On appeal, the focus of the arbitrary detention argument was a submission that the direction given by the Attorney-General on 14 January 2009 that Mr M be detained as a special care recipient was an unlawful and arbitrary Executive detention. Mr Ellis submitted that:

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60 High Court judgment, above n 2, at [704].
61 At [697].
62 At [698].

(a) The detention was not authorised by the MI Criminal Procedure Act because the Attorney-General's direction was given after the expiry of the period of detention prescribed by s 30.

(b) Even if the detention was lawful, it was arbitrary because the decision was made by the Executive, and because the detention was inconsistent with the CRPD.

[140] Mr Ellis also referred in this context to the CRPD Committee's Guidelines expressing the view that detention of persons who are unfit to stand trial, without the opportunity to defend themselves against criminal charges at a trial, amounts to arbitrary deprivation of liberty.[63]

Analysis — arbitrary detention

[141] We do not accept the proposition that the detention of Mr M under the MI Criminal Procedure Act and the ID Care and Rehabilitation Act was arbitrary solely because his liability to be detained under that regime resulted from a finding that he was unfit to stand trial. The order for his detention was not based on his disability or on his unfitness to stand trial. As explained above, the finding of unfitness to stand trial could have resulted in a number of dispositions, including discharge. The order for Mr M's detention was made, and was extended on a number of occasions, because that detention was necessary in the interests of public safety. His detention was lawful (putting to one side, for the time being, the argument about ss 30 and 31 of the MI Criminal Procedure Act which we address below). A detention that is lawful may nonetheless be arbitrary and inconsistent with s 22 of NZBORA if it is capricious, unreasoned, without reasonable cause, imposed without reference to adequate determining principles, or imposed without following proper procedures.[64] The only issues of that kind that were identified by Mr Ellis related to the Attorney-General's s 31(4) direction given in January 2009.

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63 CRPD Committee Guidelines, above n 39, at [13]. See also [6].
64 *Neilsen v Attorney-General* [2001] 3 NZLR 433 (CA) at [34].

[142] We therefore turn to consider that direction. Did the gap between the expiry of the maximum period of detention referred to in s 30 of the MI Criminal Procedure Act on 20 December 2008 and the Attorney-General's direction under s 31(4) of the MI Criminal Procedure Act issued on 14 January 2009 mean that detention pursuant to the Attorney-General's direction was unlawful, and therefore arbitrary? Even if it was lawful, was it nonetheless arbitrary because it was an Executive detention, or because it was inconsistent with the CRPD?

[143] We agree with the Judge's reading of ss 30 and 31 of the MI Criminal Procedure Act. The drafting of s 30(3) is somewhat clumsy. Read in isolation it could be taken to mean that the period of detention expires at the end of the maximum period prescribed in subs (1). But reading the provisions together as a whole, that conclusion makes no sense. The Attorney-General's power and duty to give a direction under s 31(4) when the maximum period specified in s 30 expires, if the other criteria set out in that provision are met, does not terminate at the precise moment of expiry of that period. On the approach contended for by Mr Ellis, the power would be exercisable only at the very instant that the period expires. If that moment was missed the individual would have to be released — even though that is not one of the outcomes contemplated by the legislation. A reading of the provisions that produces that absurd result cannot have been intended by Parliament, and is not an available meaning that could be adopted under s 6 of NZBORA.

[144] We also agree with the Judge that the Attorney-General's direction did not amount to detention by an act of the Executive. The issue of the direction by the Attorney-General was required by statute. That is, it was authorised by Parliament. It involved no discretion. The Attorney-General was required to issue the direction: this is an orthodox example of the Executive implementing Parliament's will, not a detention initiated by the Executive or resulting from Executive decision-making. And as the Judge noted, the direction is treated as a compulsory care order for the purposes of the ID Care and Rehabilitation Act, and is subject to the consequential safeguards prescribed by that Act.

[145] The argument that the direction was unlawful because it was inconsistent with the CRPD faces the insuperable difficulty that New Zealand law required the

Attorney-General to give the direction. No discretion was involved. The CRPD cannot affect the lawfulness of the giving of a direction in those circumstances.

[146] The argument that Mr M's detention from January 2009 onwards was arbitrary has not been made out.

Sixth ground of appeal — s 76 MH Assessment and Treatment Act

The issue

[147] Section 76 of the MH Assessment and Treatment Act provides:

> **76 Clinical reviews of persons subject to compulsory treatment orders**
>
> (1) The responsible clinician shall conduct a formal review of the condition of every patient, other than a restricted patient, who is subject to a compulsory treatment order or subject to an order under section 34(1)(a)(i) of the Criminal Procedure (Mentally Impaired Persons) Act 2003—
>
> (a) not later than 3 months after the date of the order; and
>
> (b) thereafter at intervals of not longer than 6 months.
>
> (1A) The responsible clinician must ensure that, before each review, a notice is given to the patient requiring him or her to attend at a place specified in the notice for the examination under subsection (2).
>
> (2) For the purposes of any such review, the responsible clinician shall—
>
> (a) examine the patient; and
>
> (b) consult with other health professionals involved in the treatment and care of the patient, and take their views into account when assessing the results of his or her review of the patient's condition.
>
> (3) At the conclusion of any such review, the responsible clinician shall record his or her findings in a certificate of clinical review in the prescribed form, stating—
>
> (a) that in his or her opinion the patient is fit to be released from compulsory status; or
>
> (b) that in his or her opinion the patient is not fit to be released from that status.
>
> (4) The responsible clinician shall send to the Director of Area Mental Health Services—

(a) the certificate of clinical review; and

(b) full particulars of the reasons for his or her opinion of the patient's condition, and any relevant reports from other health professionals involved in the case.

(5) If the responsible clinician is of the opinion that the patient is fit to be released from compulsory status, the patient shall be released from that status accordingly, and the compulsory treatment order shall be deemed to have been revoked.

(6) Despite anything in subsection (5), if the responsible clinician is of the opinion that a special patient detained in a hospital following an application made under section 45(2), or subject to an order made under section 34(1)(a)(i) of the Criminal Procedure (Mentally Impaired Persons) Act 2003, is fit to be released from compulsory status, the patient must be dealt with in accordance with section 47(1), and section 47(3) and (5) applies.

(6A) Despite anything in subsection (5), if a patient or special patient is subject to a compulsory treatment order that was made following an application under section 136(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, he or she must be dealt with in accordance with section 47A.

(7) If the responsible clinician is of the opinion that the patient is not fit to be released from compulsory status, that officer shall send a copy of the certificate of clinical review to—

(a) *[Repealed]*

(b) each of the following persons:

(i) the patient:

(ii) any welfare guardian of the patient:

(iii) the patient's principal caregiver:

(iv) the primary health care provider who usually attended the patient immediately before the patient was required to undergo assessment and treatment under Part 1:

(v) a district inspector:

(vi) an official visitor.

(8) To each of the persons specified in subparagraphs (i) to (iv) of subsection (7)(b) the responsible clinician shall also send a statement of the legal consequences of the finding set out in the certificate of clinical review, and of the recipient's right to apply to the Review Tribunal for a review of the patient's condition.

(9) The district inspector who receives a copy of the certificate of clinical review must—

(a) communicate with the patient and find out, if possible, whether or not the patient wants an application to be made to the Review Tribunal for a review of the patient's condition. The district inspector must communicate with the patient by talking to him or her, unless talking to him or her is impracticable; and

(b) decide, having regard to any view expressed by the patient, whether or not an application should be made to the Review Tribunal for a review of the patient's condition.

(10) If the district inspector considers that such an application should be made, the district inspector shall take whatever reasonable steps he or she thinks necessary to encourage or assist the patient, or any person specified in subparagraphs (ii) to (iv) of subsection (7)(b), to make such an application.

(11) If, in any case to which subsection (9) applies, the district inspector considers that an application should be made to have the patient's condition reviewed by the Review Tribunal, but neither the patient nor any person specified in subparagraphs (ii) to (iv) of subsection (7)(b) intends to make such an application, the district inspector may report the matter to the Review Tribunal; and, in such a case, the Review Tribunal may, of its own motion, review the patient's condition under section 79 or section 80 as if an appropriate application for such a review had been made to the Review Tribunal.

(12) Instead of performing personally the functions specified in subsections (9) to (11), the district inspector may in any particular case arrange for an official visitor to perform them.

[148] Before the High Court the plaintiffs argued that the s 76 clinical review process results in an Executive detention, because the assessor who carries out the examination is appointed by the Executive. The plaintiffs also argued that because the review involves a compulsory medical examination, it breaches s 11 of NZBORA which provides that "[e]veryone has the right to refuse to undergo any medical treatment".

[149] Mr Ellis also submitted that a detainee who undergoes a s 76 assessment is denied natural justice, in breach of s 27(1) of NZBORA which provides:

27 Right to justice

(1) Every person has the right to the observance of the principles of natural justice by any tribunal or other public authority which has the power to make a determination in respect of that person's rights, obligations, or interests protected or recognised by law.

[150] Mr Ellis submitted that detention following an assessment under s 76 is arbitrary and unlawful, because it is an Executive detention that results from a process that is inconsistent with ss 11 and 27(1) of NZBORA.

High Court judgment

[151] The Judge considered that the claims made in relation to s 76 of the MH Assessment and Treatment Act were based on a misapprehension about how the section operates. The detention of a special patient is initially ordered by a court under s 24 of the MI Criminal Procedure Act (or its precursor, s 115 of the CJA). After the transition to civil orders, it is ordered by the Family Court. The duration of civil orders under the MH Assessment and Treatment Act is initially limited to six months, but can be extended by the Court. It is only at the point of the second six-month extension of such an order that its duration becomes indefinite. Those indefinite orders are made by the Family Court. While those orders are in force, clinical reviews under s 76 take place every six months. These can lead to a direction that a patient be released. It is not the clinician carrying out the s 76 assessment who makes an order for the patient's continued detention. The detention is authorised by a court order. It is not correct to say that the assessor authorises the patient's continued detention, or that their continued detention is an Executive act.[65]

[152] For the same reason, comparison between a clinical review and a criminal process is inapt. So too is the importation of the notion of a "hearing" or of a right to be heard. The relevant right to be heard exists in the Family Court when the orders for detention are made. In any event, the legislation provides for rights to seek review of such assessments before a Review Tribunal, and provides rights of appeal from Review Tribunal decisions to the District Court.[66]

[153] The Judge concluded that there was no legal basis for the claims that the s 76 review process resulted in unlawful Executive detention, resulted in arbitrary detention, involved a breach of natural justice or was analogous to a criminal hearing without a right to legal representation.[67]

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65 High Court judgment, above n 2, at [707]–[709].
66 At [709].
67 At [710].

Appellant's argument on appeal

[154] Mr Ellis reiterated the submission he made in the High Court that detention following a s 76 assessment is arbitrary and unlawful, as it is a de facto Executive detention in breach of ss 11 and 27(1) of NZBORA.

[155] Mr Ellis accepted the correctness of the Judge's finding that clinicians carrying out s 76 assessments do not make an order for detention. However, he submitted, the reality is that:

> … the clinician has the keys to the mental hospital in his or her hands. If he, or she, makes a decision that the detainee is still unwell, the detention continues. This de facto causes an [E]xecutive detention.

[156] Mr Ellis submitted that the involvement of District Inspectors in deciding whether to seek a review by the Review Tribunal limits the legal and practical right of the detainee to challenge the s 76 decision.

[157] Mr Ellis also submitted that the requirement under s 76(1A) that the patient attend an examination creates a compulsory medical examination, in breach of s 11 of NZBORA. There is no requirement for the reviewer to consult with the detainee or anyone on behalf of the detainee, and no right to legal representation in connection with the assessment, contrary to the requirements of natural justice and to s 27 of NZBORA.

Analysis

[158] We agree with the Judge that the argument that the s 76 assessment process results in an Executive detention is misconceived. A patient can only be detained under the MI Criminal Procedure Act (or its precursor) pursuant to a court order. It is the court order that authorises the continuing detention of the patient. A s 76 review can trigger the release of a patient. It cannot authorise detention beyond the period authorised by a court order.

[159] The detention process respects natural justice rights by providing for the patient to be heard by the court when an order for detention is made, providing for appeal rights in respect of that decision, and providing for rights of review in relation

to the outcome of the s 76 assessment. The principles of natural justice affirmed by s 27(1) of NZBORA do not require the person undergoing a s 76 assessment to be legally represented at that assessment, and do not require an opportunity to make submissions in the context of such an assessment.

[160] The analogy with a criminal hearing is misconceived. A clinical review is a professional medical examination of an inquisitorial nature. A full opportunity to be heard is provided at the initial making of the detention order. The ability to apply for a review before the Review Tribunal provides further, appropriate, safeguards.

[161] The complaint that a District Inspector may choose not to seek a review of an unfavourable assessment under s 76 is beside the point. If the clinician considers that the patient is not fit to be released from compulsory status, they are required to send the certificate of clinical review to all the recipients prescribed in s 76(7), including the patient and any welfare guardian of the patient. Each of these recipients has standing to apply to the Review Tribunal for a review of the patient's condition.

[162] We also agree with the Judge that the assessment contemplated by s 76 is not medical treatment for the purposes of s 11 of NZBORA. Mr Ellis submitted that NZBORA rights attach to a medical examination. We accept that a medical examination can amount to treatment for the purposes of s 11, where it is carried out for the purpose of diagnosing and treating an ailment.[68] But Mr Ellis referred us to no authority for the proposition that a forensic assessment of the kind required by s 76 comes within the scope of the phrase "medical treatment" for the purposes of s 11 of NZBORA, and we agree with the Judge that it does not.[69]

[163] Mr Ellis is of course right to say that detention which is lawful may nonetheless be arbitrary, in contravention of s 22 of NZBORA. As noted above, a detention will be arbitrary if it is capricious, unreasoned, without reasonable cause, imposed without reference to adequate determining principles, or imposed without following proper

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68 Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A commentary* (2nd ed, LexisNexis, Wellington, 2015) at [11.9.6], referring to *M v Attorney-General* [2006] NZFLR 181 (HC) at [107]. See also [11.9.9] and [11.9.12].

69 Butler, above n 68, at [11.9.14].

procedures.[70] However in his submissions on appeal Mr Ellis did not identify any factors in relation to the s 76 process other than those discussed above which might be seen as indicia of arbitrariness. We have concluded that those factors are not made out. To the extent that this argument rested on the detention being inconsistent with the CRPD as interpreted by the CRPD's guidelines on art 14, we do not accept the underlying proposition that the detention of an intellectually disabled person who poses a risk to himself or to the public is by its very nature arbitrary for the purposes of the NZBORA, for the reasons explained at [141] above.

[164] This ground of appeal must therefore fail.

Seventh ground of appeal — failing to advise Mr M of his right to obtain a second opinion

The issue

[165] Before the High Court the plaintiffs claimed that they were not advised of, and/or afforded, the right to obtain a second opinion from a medical practitioner in respect of the medical assessments that underpin the continuation of their detention under the ID Care and Rehabilitation Act.

[166] Section 77 of the ID Care and Rehabilitation Act provides for regular clinical reviews of the condition of every care recipient who is subject to a court order, at intervals of not more than six months.

[167] Section 49 of the ID Care and Rehabilitation Act provides a care recipient with certain rights to information:

> **49 General rights to information**
>
> (1) As soon as a court order (as defined in section 5) is made in respect of a care recipient, the care recipient's care manager must—
>
> (a) explain to the care recipient, in a manner that the care recipient is most likely to understand, the care recipient's rights under this Act, including, so far as applicable, the rights specified in subsection (2); and

[70] *Neilsen v Attorney-General*, above n 64, at [34].

(b) give a guardian of the care recipient or, if the care recipient does not have a guardian, the care recipient's principal caregiver a written statement of the care recipient's rights.

(2) A care recipient's care manager must keep the care recipient informed, in a manner that the care recipient is most likely to understand, of his or her rights as a care recipient and, in particular, about—

(a) the care recipient's legal status as a care recipient; and

(b) the care recipient's right to have his or her condition reviewed by a specialist assessor in accordance with section 77; and

(c) the care recipient's right to seek a judicial inquiry under section 102; and

(d) the functions and duties of district inspectors designated under this Act.

(3) A care manager of a care recipient must also keep the care recipient's guardian, or, if the care recipient does not have a guardian, the care recipient's principal care giver informed of the matters stated in subsection (2).

[168] Section 102 of the ID Care and Rehabilitation Act, which is referred to in s 49(2), provides as follows:

102 Judge may call for report on care recipient or summon care recipient

(1) A High Court Judge may make an order directing a district inspector or 1 or more other persons—

(a) to visit and examine a care recipient who is detained in a facility; and

(b) to inquire into and report on any matter relating to that care recipient that the Judge specifies.

(2) Whether an order under subsection (1) has been made or not, a High Court Judge may make an order directing a care manager to bring a care recipient for whom the care manager is responsible before the Judge in open court or in Chambers, for examination at a time specified in the order.

(3) An order under subsection (1) or (2) may be made on the Judge's own initiative or on the application of any person.

High Court judgment

[169] The Judge rejected this claim on the facts. The Judge said:

> [805] The evidence was that the applicants are advised of their rights, including the right to obtain a second opinion, as part of the process of unit induction. There is no evidence the respondents failed to meet the duty to keep the applicants informed of their rights under s 64 [MH Assessment and Treatment Act] and s 49 [ID Care and Rehabilitation Act]. And as a matter of fact second opinions were sought on occasion.

Appellant's argument

[170] Mr Ellis argued that this was an inadequate response in respect of a 13-year detention. He said the respondents needed to prove that second opinions were sought, that Mr M was advised they could be sought after each opinion was provided, and that the opinions were sought from outside the District Health Board so they would be independent. Mr Ellis submitted that advice about rights is often necessary in order that people may fully utilise them.[71] The opportunity to benefit from a second independent psychiatric opinion is an important safeguard against possible arbitrariness in decision-making concerning the continuation of detention.[72]

[171] In the course of argument, Mr Ellis accepted that s 49(2) of the ID Care and Rehabilitation Act was on its face satisfactory, but submitted that its implementation was not adequate. When asked what evidence there was that the s 49(2) obligations were not adequately performed, Mr Ellis said that an inference to that effect could be drawn from the lack of use of the s 102 judicial inquiry mechanism.

Analysis

[172] The ID Care and Rehabilitation Act does not provide a right to a second independent medical assessment following a s 77 assessment. But the s 77 assessment is itself a mandatory periodic assessment of whether continued detention is necessary. And s 102 provides for review of a care recipient's detention by a High Court Judge, who can direct that a further medical assessment be obtained for the purposes of that review.

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71 *R v Mallison* [1993] 1 NZLR 528 (CA) at 532.
72 *X v Finland* ECHR 34806/04, 3 July 2012 at [169].

[173] Mr Ellis did not challenge the Judge's factual finding that patients are advised of their rights as part of the process of unit induction, including the right to have their condition reviewed under s 77 and the right to seek a judicial inquiry under s 102. As the Judge said, there was no evidence that the respondents failed to meet their duty under s 49(2) to keep Mr M informed of his rights under the ID Care and Rehabilitation Act during the period when he was detained under that Act, including his right to periodic assessments under s 77 and his right to seek a judicial inquiry under s 102. Mr Ellis argued that the onus of proof should be reversed on this issue, and that the respondents should be required to establish that the s 49 obligation was performed on every relevant occasion. However he did not identify any legal rationale for this argument that the burden of proof should be reversed. As noted above at [43]–[45], these are ordinary civil proceedings. Mr M needed to lay an evidential foundation for his complaint that s 49(2) had not been complied with. In the absence of such evidence, the Judge's conclusion was inevitable.

Eighth ground of appeal — breach of Article 11 of the Convention against Torture

[174] Article 11 of the CAT provides:

> Each State Party shall keep under systematic review interrogation rules, instructions, methods and practices as well as arrangements for the custody and treatment of persons subjected to any form of arrest, detention or imprisonment in any territory under its jurisdiction, with a view to preventing any cases of torture.

[175] Before the High Court the plaintiffs argued that their detention was arbitrary and in breach of s 22 of NZBORA because, among other matters, there had been a failure to systematically review policies such as the "no sex" policy, in breach of art 11 of the CAT.

High Court judgment

[176] The Judge addressed this complaint as follows:

> [807] No issues about "interrogation rules, instructions, methods and practices" arise in the present case. The many and varied mechanisms whereby the custody and treatment of the applicants while detained is or can be systematically reviewed have been dealt with elsewhere. And as I have recorded earlier above, the conditions of the applicants' detention have been

> specifically monitored by reference to the Convention Against Torture by the Ombudsman with no relevant concerns identified.

Appellant's argument

[177] Mr Ellis submits that the Judge misunderstood the claim: individual reviews from time to time are different from a requirement to systematically review policies such as the "no sex" policy, as required by art 11. Nor is that requirement met by periodic spot checks of facilities by the Ombudsman.

[178] Mr Ellis accepted the correctness of the Crown's submission that this ground of appeal must founder on the principle that international treaty obligations are not binding in domestic law. However he told us that he cannot raise the issue with the CAT Committee unless it had been raised in the domestic courts first. He noted that he had raised it.

Analysis

[179] This claim is not based on any requirement for systematic reviews of the relevant policies under domestic law. Article 11 of the CAT is not directly enforceable before a New Zealand court. New Zealand's obligation under art 11 to carry out systematic reviews of relevant policies is not the kind of obligation that needs to be transposed into domestic law in order to be effective. Rather, the New Zealand government can perform its international obligations under art 11 of the CAT by making administrative arrangements for reviews of relevant policies. It is not the function of the New Zealand courts to assess the adequacy of such arrangements to meet the requirements of art 11.

[180] Mr Ellis is right to say that the availability of individual reviews in respect of particular individuals is not relevant to the complaint he makes about an absence of provision for systematic review of relevant policies. But he did not identify any evidence to support his submission that relevant policies had not been reviewed in a systematic way between 2001 and 2013, or explain why the absence of provision for systematic reviews would mean that detention of Mr M was arbitrary in the sense described at [163] above.

[181] This ground of appeal was not made out on the facts, or as a matter of New Zealand law.

Ninth ground of appeal — failing to give the appellant his NZBORA rights

[182] Before the High Court, the plaintiffs argued that medical assessments which may result in their continued detention engaged their rights under ss 11 and 27 of NZBORA and under the CRPD. They argued that before participating in such assessments they should have been advised of these rights, in the same way that a suspect is advised of NZBORA rights before a police interview.

High Court judgment

[183] The Judge considered that this allegation was based on a misapprehension. Put simply, the regular medical assessments and reviews never formed the basis for the plaintiffs' detentions and NZBORA rights were not therefore engaged. They were detained by order of the court.[73] The Judge had previously explained her view that these arguments were based on misapprehensions about the function of clinical reviews within the scheme of the MH Assessment and Treatment Act.[74] It is not the clinician who makes an order for a person's continued detention.

Appellant's argument

[184] Mr Ellis submitted that the medical reviews carried out periodically under the legislation formed the basis for Mr M's detention, or were its legal cause.

[185] Mr Ellis did not explain what form the advice of rights should take, or what choices a care recipient would be better placed to make in light of such advice.

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73 High Court judgment, above n 2, at [808].
74 At [708]–[710].

[186] The rights that Mr Ellis identified as of particular relevance are:

(a) the right to refuse to undergo any medical treatment, under s 11 of NZBORA; and

(b) the right to justice, under s 27 of NZBORA.

[187] Section 11 of NZBORA provides that "[e]veryone has the right to refuse to undergo any medical treatment".

[188] Section 27 of NZBORA provides as follows:

> **27 Right to justice**
>
> (1) Every person has the right to the observance of the principles of natural justice by any tribunal or other public authority which has the power to make a determination in respect of that person's rights, obligations, or interests protected or recognised by law.
>
> (2) Every person whose rights, obligations, or interests protected or recognised by law have been affected by a determination of any tribunal or other public authority has the right to apply, in accordance with law, for judicial review of that determination.
>
> (3) Every person has the right to bring civil proceedings against, and to defend civil proceedings brought by, the Crown, and to have those proceedings heard, according to law, in the same way as civil proceedings between individuals.

Analysis

[189] We doubt that an assessment under s 77 of the ID Care and Rehabilitation Act amounts to medical treatment for the purposes of s 11 of NZBORA, for the reasons set out at [162] above.

[190] Nor was it explained to us what advice should be given about the rights protected by s 27 of NZBORA prior to a s 77 assessment. As noted above, the principles of natural justice are fully observed in the court process that leads to any order for detention: the affected person has a right to be heard (and to be legally represented) before any order is made under ss 24 or 25 of the MI Criminal Procedure Act. There is a right of appeal from a decision under ss 24 or 25. The clinician conducting a s 77 review is not making a determination in respect of the affected

person's rights, so s 27(1) is not relevant to the conduct of the s 77 assessment. We also doubt that s 27(2) applies to a s 77 assessment, but in any event s 102 of the ID Care and Rehabilitation Act expressly provides for judicial inquiries into the condition, and continuing detention, of a care recipient. We do not consider that advice about any rights under s 27(2) needs to be provided before a s 77 assessment is carried out. And as noted above, a care recipient's care manager is required by s 49(2) to keep the care recipient informed about their rights, including their right to seek a s 102 judicial inquiry.

[191] Mr Ellis did not explain which rights under the CRPD were engaged by a s 77 assessment, or how those rights would be better given effect if Mr M had been advised of them before medical assessments took place.

[192] There is some force in the Crown's submission that the argument that there has been a failure to give Mr M notice of his rights under ss 11 and 27 of NZBORA and the CRPD was vague, and could not sensibly be responded to. We agree with the Judge that the argument — at least as we understand it — appears to us to be based on a misapprehension about the nature of s 77 assessments.

[193] The Judge was right to dismiss this ground of challenge to the treatment of Mr M.

Tenth ground of appeal — totality argument

[194] Mr Ellis submitted that the totality of errors of law when taken together affected the Judge's approach to the determination of the case. She incorrectly applied a traditional, conservative approach to disability. The CRPD was intended to replace this approach by a "paradigm shift", and the submissions advancing that proposition were not properly considered.

[195] We have already found that the nine specific grounds of appeal set out above have not been made out. We are satisfied that the Judge was right to dismiss all of the claims that were the subject of the appeal to this Court, applying the approach to those claims outlined at [29] to [36] above. The CRPD does not provide a directly enforceable standard for review of the respondents' actions as a matter of New Zealand

law. The Judge correctly took the CRPD into account to inform the interpretation and application of relevant New Zealand legislation. To the extent that the approach to the CRPD contended for by Mr Ellis is not reflected in the outcome of the proceedings, that is because his preferred approach has not been incorporated in the relevant New Zealand legislation. The task of the courts is to apply that legislation, not to issue rulings on whether the legislation is consistent with the CRPD.

[196] In those circumstances, the "totality argument" advanced by Mr Ellis also cannot succeed.

Result

[197] The appeal is dismissed.

[198] Mr M is legally aided. We make no order as to costs.

Solicitors:
Crown Law Office, Wellington for First Respondent
Luke Cunningham & Clere, Wellington for Second and Third Respondents