THE NAMES AND ANY IDENTIFYING PARTICULARS OF EACH OF THE APPLICANTS ARE SUPPRESSED.

IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

I TE KŌTI MATUA O AOTEAROA
TE WHANGANUI-Ā-TARA ROHE

CIV-2010-485-379
[2017] NZHC 2629

IN THE MATTER OF	Applications for Declarations and Compensation for involuntary placement in Psychiatric Institutions leading to breach of a range of domestic and international human rights instruments
BETWEEN	S First Applicant
	M Second Applicant
	C Third Applicant
AND	ATTORNEY-GENERAL First Respondent
	CAPITAL & COAST DISTRICT HEALTH BOARD Second Respondent
	WAITEMATA DISTRICT HEALTH BOARD Third Respondent
	MENTAL HEALTH REVIEW TRIBUNAL Fourth Respondent
	A DISTRICT INSPECTOR Fifth Respondent

Hearing:	25 July 2016 - 2 September 2016 Further memoranda, conferences and applications 16 and 27 September 2016, 7 February, 13 March, 21 March, 3 April, 21 April, 1 June, 7 June, 12 June, 26 June, 7 July, 24 July, 18 August and 25 September 2017 and further hearing on 28 September 2017
Counsel:	T Ellis and S Ruthven for Applicants M Coleman and M McKillop for First Respondent D La Hood, I Auld and K Orpin-Dowell for Second and Third Respondents P Gunn for Fourth and Fifth Respondents (abiding) B Wilson assisting the Court
Judgment:	30 October 2017

JUDGMENT OF ELLIS J

Table of Contents

[1] Each of the three applicants, Mr S, Mr M and Mr C, is intellectually disabled.[1] Each also has other conditions which mean that he falls within the statutory definition of "mentally disordered". More specifically:

(a) Mr S has a mild to moderate intellectual disability, is autistic and also has an intermittent bi-polar affective disorder.

(b) Mr M has a moderate intellectual disability and a personality disorder with borderline anti-social and narcissistic personality traits.

(c) Mr C has autism, a schizoaffective disorder, a mild intellectual disability and epilepsy.

[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.[2]

[3] In these proceedings Messrs S, M and C have challenged (through their litigation guardians) the fact, circumstances and conditions of their detention from 2000 onwards. They say that the operation of the statutory provisions authorising their initial and continued detention are unlawfully discriminatory in breach of s 19 of the New Zealand Bill of Rights Act 1990. They seek declarations that aspects of their treatment while detained constituted torture or was cruel and inhumane, in breach of ss 9 and 23(5) of the New Zealand Bill of Rights Act 1990 (NZBORA). They claim

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1 In very general terms, each has an IQ of less than 70. The statutory definition of "intellectual disability" is set out at [60] and [61] below.

2 Mr M is no longer subject to a compulsory treatment or care orders and lives in supported accommodation in the community.

their detention has been punitive rather than protective and was, or became, arbitrary, in breach of s 22 of the NZBORA.

STRUCTURE OF THIS JUDGMENT

[4] This judgment is structured in two broad parts. The first is in the nature of background, and addresses:

(a) the claim in overview;

(b) procedural matters and the trial process, including:

(i) the litigation guardian issue;

(ii) the applicants' witnesses;

(iii) the respondents' witnesses;

(iv) the site visits; and

(v) alleged unfairness of the process;

(c) the relevant legislation, namely:

(i) the criminal justice gateway to the detention of those with intellectual disabilities;

(ii) the legislative provisions governing their continued detention, the conditions of their detention and their treatment; [3]

(iii) the relevant oversight mechanisms; and

(d) the (largely uncontested) evidence about:

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[3] More specific statutory provisions and guidelines (such as those which relate, for example, to the use of seclusion and restraint) will be addressed under the specific causes of action which relate to the issues with which they deal.

(i) the facilities in which the applicants have been detained over the years; and

(ii) the applicants themselves, including their personal history, circumstances and medical presentation and the way in which the relevant statutory processes have applied to them.

[5] The second part of this judgment essentially addresses the specific causes of action. But because sections 9 and 23(5) of the NZBORA form the basis for the majority of the applicants' claims, a discussion about those sections and the Court's proposed approach to them is included at the beginning.

THE CLAIM IN OVERVIEW

[6] The claim was originally filed in 2010 and was amended subsequently, and again in October 2014. Its focus from a temporal perspective is on the applicants' detention and treatment between 2000 and 2012.[4] Because of the nature and time-span of the claim it engages a number of statutes, both current and repealed, and the sometimes complex interplay between them. In particular, it involves the operation of, and processes under:

(a) part 7 of the Criminal Justice Act 1985 (the CJA)[5];

(b) the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHCAT Act);

(c) the Criminal Procedure (Mentally Impaired Persons) Act 2003 (the CPMIP Act); and

(d) the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the IDCCR Act).

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4 One aspect of the claim relates to events in late 1999.

5 Repealed in 2004.

[7] The second amended statement of claim contains some 13 causes of action and is nearly 600 paragraphs long. It contains a plethora of factual allegations spanning, as I have said, a 12 year period. Those allegations are said to give rise to numerous, overlapping grounds of legal challenge. The pleading was justifiably criticised by counsel for the respondents as prolix, repetitive and confusing.

[8] In the course of the six week trial:

(a) leave was sought and granted to amend the sixth cause of action; and

(b) other aspects of the claims were, quite properly, abandoned, namely:

(i) the second (negligence) cause of action relating to alleged sexual offending against Mr S in 1999/2000;

(ii) claims relating to the ban on smoking; and

(iii) claims alleging medical experimentation.

[9] No doubt due to the enormity of the task which he had set himself, Mr Ellis for the applicants did not pursue all aspects of the remaining causes of action at trial. In that way at least, the applicants' case became narrower and more focused as the hearing went on.

[10] What remains of the claims may be summarised as follows:

(a) the first cause of action, which relates to sexual abuse said to have been suffered by Mr S at the hands of another patient, in 1999/2000;

(b) the third cause of action which also relates to these allegations of sexual abuse;

(c) the fourth cause of action which relates to aspects of the applicants' care, treatment and rehabilitation;

(d) the fifth cause of action which relates to sexual expression;

(e) the sixth cause of action which principally concerns the use of restraint and seclusion but also includes an unrelated issue about Mr S's correspondence;

(f) the seventh cause of action which concerns a decision of the Mental Health Review Tribunal (the MHRT) on 29 March 2007 about Mr S;

(g) the eighth cause of action which relates to general living conditions at "Porirua Hospital";

(h) the ninth cause of action which focuses on the allegations of arbitrary detention and discrimination;

(i) the tenth cause of action which concerns issues of medical treatment and consent;

(j) the eleventh cause of action which relates to review processes;

(k) the twelfth cause of action which is essentially an omnibus or "totality" claim; and

(l) the thirteenth cause of action which, again, relates to Mr S's allegations of sexual abuse in 1999/2000.

[11] As a matter of both practical and legal necessity, however, this judgment addresses only those of the factual claims which have some proper evidentiary foundation. I endorse and adopt the approach taken by the respondents in closing submissions, namely that where evidence was either not adduced or not put (in accordance with s 92 of the Evidence Act 2006), the relevant aspects of the claims are treated as abandoned.

[12] I also record at the outset that these proceedings are not, and could never be, some form of Commission of Inquiry into past and present forensic disability services

in New Zealand. That is not this Court's function. And nor is it the Court's function to second-guess clinical decisions made in good faith, or issues of disability or clinical policy.

PROCEDURAL MATTERS AND THE TRIAL PROCESS

The litigation guardian issue

[13] When the proceedings were first filed in March 2010 an application was also made to commence proceedings without a litigation guardian.[6] Dobson J declined that application on the grounds that, given the applicants' disabilities, r 4.30 required a litigation guardian to be appointed.[7]

[14] Following that decision, there was an application that Mr Colin Burgering be appointed as litigation guardian for Messrs S, M and C. Mr Burgering was a member of the Justice Action Group (JAG) and had, from time to time, taken on a support and advocacy role for the applicants.[8] That application was granted by MacKenzie J.[9]

[15] Subsequently, however, the applicants filed a further application seeking to dispense with their litigation guardian and seeking a declaration that r 4.30 was unlawful. But Ronald Young J held that r 4.30 was not discriminatory and did not breach the Convention on the Rights of Persons with Disabilities 2006 (CRPD).[10] 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 said the Convention anticipated such an accommodation.[11]

[16] Notwithstanding Ronald Young J's reasoned and express findings on the issue Mr Ellis sought to relitigate it before me. In response to the proposition that the matter

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6 The application was consistent with one of the pleadings repeated throughout the statement of claim, namely that High Court Rule 4.30 (which requires incapacitated persons who are involved in proceedings to have a litigation guardian) was unlawfully discriminatory.

7 *S v Attorney-General* HC Wellington CIV-2010-485-379, Minute of Dobson J, 22 June 2010.

8 JAG is a lobby group concerned with promoting the rights of those with intellectual disabilities.

9 *S v Attorney-General* HC Wellington CIV-2010-485-379, Minute of McKenzie J, 13 April 2011.

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

11 In the context of that interlocutory skirmish the applicants resiled from their earlier acceptance that they were incapacitated persons in terms of HCR 4.29. Although it was suggested that that question (and the relevant medical evidence) could be explored at trial, it was not something that was pursued before me.

was res judicata, he said that it was not, because since Young J's decision, the UN Committee on the Rights of Persons with Disabilities has issued General Comment 1 on art 12 of the CRPD.

[17] Article 12 relevantly provides that:

> 1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
>
> 2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
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> 3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
>
> 4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.
>
> 5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

[18] General Comment 1 states that the effect of art 12 is that lacking the "mental capacity" to make a particular decision is not adequate grounds for being considered to lack "legal capacity" to make that decision. It also states that mental capacity testing on a functional basis (that is, the situational competency approach taken in New Zealand, whereby medical practitioners examine a person's ability to absorb, understand and consider information about a particular subject, and to communicate a decision) is unlawful.

[19] This unlawfulness is said to be a result of "mental capacity" testing being discriminatorily applied to people with disabilities, and the impossibility of knowing

"the inner workings of the human mind". The Committee expressed the view that the CRPD prohibits substituted decision-making for people with intellectual disabilities, and requires States to replace such regimes with "supported" decision-making regimes.

[20] Putting to one side the controversy created by this aspect of the General Comment[12], its recent release does not enable the Court to ignore the operation of the res judicata doctrine in relation to this issue. Ronald Young J has already expressly held that the litigation guardian rules were not inconsistent with the CRPD. He made that finding in relation to these proceedings and as between the present parties. That the Committee has subsequently expressed a different view does not alter the finality of that determination.[13]

[21] All I will therefore say about the General Comment is that its import would appear to be that treating those with intellectual disabilities differently from those without such disabilities will always be discriminatory, however beneficial or preferential such treatment might be. It certainly seems to run contrary to most States' parties understanding of the Convention, including New Zealand's. The New Zealand understanding finds expression (for example) in the Disability (United Nations Convention on the Rights of Persons with Disabilities) Act 2008, which substituted status-based disability exclusions throughout previous New Zealand legislation (which *did* discriminate against people on the basis of their disabilities) with capacity-based exclusions.[14]

Post-hearing development – Mr Burgering's death

[22] In February 2017, and before I had had the opportunity to issue this judgment, the Court received advice that Mr Burgering had died. The relevant High Court Rules say that, in those circumstances, no further step may be taken in a proceeding unless

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12 See for example Melvyn Freeman and others "Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities" (2015) 2(9) *The Lancet Psychiatry* 844.

13 There was no appeal from Ronald Young J's decision.

14 This meant that references to persons subject to the MHCAT Act (and the previous Mental Health Act 1969) throughout New Zealand legislation were replaced by references to people subject to personal and/or property orders under the PPPR Act. PPPR Act orders can arise for any number of reasons giving rise to incapacity. It is not a status-based refusal of legal capacity.

and until another guardian is appointed. I formed the preliminary view that that meant that a new litigation guardian (or guardians) should be appointed prior to releasing this judgment. Regardless of whether issuing a judgment can strictly be regarded as a "step in the proceeding" it seemed to me that, in the absence of a litigation guardian, any appeal rights that the applicants might wish to exercise would undoubtedly be prejudiced. Moreover, it had been agreed with counsel at the end of the hearing that the litigation guardian might well have an important role in explaining the judgment to the applicants in a way that did not cause them anxiety or distress.

[23] The need to appoint a new litigation guardian or guardians was complicated by the fact that proceedings were then in train to have Mr S's sister appointed as his welfare guardian to have Mr C's father appointed as Mr C's welfare guardian.[15] On the authority of this Court in *B v Waitemata District Health Board* those appointed as a person's welfare guardian for general purposes are also required to act as that person's litigation guardian.[16]

[24] But Mr Ellis disputed the correctness of *B* and wished to have Mr Michael Bott appointed as the litigation guardian for both Mr S and Mr C, as well as Mr M (who does not have a welfare guardian) and wished to have a further hearing about the issue. One was duly scheduled for late September 2017.

[25] Just prior to that hearing, however, a process was agreed between counsel whereby a District Inspector would speak to both Mr S and Mr C about their wishes and also to their respective welfare guardians. The outcome of that process was advice to the Court that both men wished their welfare guardians to be their litigation guardians. Orders were made to that effect. Mr Bott was appointed as Mr M's litigation guardian without opposition.

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15 Those appointments were made on 19 June 2017 and 16 May 2017 respectively.

16 *B v Waitemata District Health Board* [2013] NZHC 852, (2013) 21 PRNZ 429.

The applicants' evidence

Process

[26] The applicants' respective disabilities presented obvious difficulties in terms of their capacity (in the literal sense) to give evidence and to be cross-examined. Their literacy skills range from non-existent to very modest, their concentration spans are limited and each suffers from some kind of anxiety disorder. They tend to respond poorly, and sometimes violently, to situations of stress. For those who are unfamiliar with them, they can be difficult to understand.

[27] Initially, briefs of evidence written by Mr Burgering and signed by the applicants were prepared. But the respondents expressed concern that the briefs contained no indication that they had been read aloud and explained to, or understood by, the applicants (as required for the swearing of an affidavit by an illiterate person in r 9.84). There can be no doubt that the applicants would have been unable to read these briefs when giving evidence and, as I have said, would have found any Court appearance (let alone cross-examination) extremely stressful.

[28] For these reasons, counsel for the respondents proposed, and then facilitated, a process whereby the applicants' evidence was given by a DVD recording made before the hearing, pursuant to an order made under ss 103 and 105(1)(a)(iii) of the Evidence Act 2006, without the need for cross-examination. The following procedure was adopted:

(a) the applicants each underwent an evidential video interview by a specialist interviewer experienced in conducting evidential video interviews with intellectually disabled people;

(b) the interviewers were provided by the New Zealand Police, who have specialist expertise in this area. The Police also organised the logistics of conducting the interviews;

(c) the interviewers were provided with material to assist them to understand the case, as agreed between the parties;

(d) counsel conferred, both with each other and with the interviewers, to create interview plans, in order to ensure that the interviews canvas all of the matters that counsel wished the claimants to be questioned about;

(e) counsel monitored the interviews and provided feedback and direction to the interviewers at pre-determined stages throughout the interviews; and

(f) the interviews were conducted where each of the applicants reside, in order to minimise stress on them.

[29] As a result, all the clinicians who gave evidence at trial who had seen the DVDs and who were familiar with the applicants confirmed that the recordings showed them at "their best".

[30] This process and, indeed, the conduct of the respondents throughout these proceedings, were very fairly and properly praised by Mr Ellis in his opening submissions. He said:

> Indeed the way the litigation has been conducted encapsulates the notion of the Crown—an ideal litigant. Counsel is grateful for the very helpful approach adopted.

[31] I agree.

Mr Burgering and Dr Webb

[32] The other evidence called by Mr Ellis for the applicants was from the (now) late litigation guardian Mr Burgering and from Dr Olive Webb, a psychologist who gave evidence as an expert.

[33] Mr Burgering's evidence was brief and I need say no more about it here. It is, however, necessary to say a little more about the evidence of Dr Webb.

[34] Dr Webb said that she had reviewed all the files relating to the applicants care and treatment over the period covered by the claim. Those files are, undoubtedly,

voluminous. She had also interviewed the applicants and spoken to a number of their clinicians. She presented as a woman of strong views about intellectual disability policy and the care and treatment of those who are intellectually disabled. I do not doubt the strength of her convictions or that they are well motivated. But it is fair to say, however, that by and large I did not find her evidence substantially helpful. The language in which she expressed some of her views was unnecessarily emotive; it detracted from the content and gave rise to doubts about her impartiality. Nor, in my view, were her sometimes strident criticisms of the care that the applicants have received over the years justified. Nonetheless I do not discount her evidence completely and will refer to aspects of her evidence in the course of this judgment.

The respondents' evidence

[35] The respondents called a number of witnesses whose evidence covered three general areas.

[36] The evidence of the first group of witnesses explained the forensic intellectual disability and mental health system. The witnesses in that group were:

(a) Ms Rachel Daysh, who is the National Manager of Intellectual Disability Services at CCDHB. Her role includes management of the National Intellectual Disability Care Agency (NIDCA);

(b) Dr Amanda Smith, who is the Chief Advisor, Disability, and Director for the IDCCR Act at the Ministry of Health; and

(c) Dr Anthony Duncan who is the National Advisor in relation to the IDCCR Act. He was formerly Deputy Director and Senior Advisor in Mental Health at the Ministry of Health and gave evidence about the operation of the MHCAT Act.

[37] The evidence of the second group of witnesses related to the Pōhutukawa Unit at the Mason Clinic in Auckland, where Mr M was, for a time, detained and where Mr C remains detained. The witnesses in that group were:

(a) Dr Jeremy Skipworth, who is the Clinical Director at the Mason Clinic; and

(b) Dr Mhairi Duff, a clinical psychologist and psychiatrist, who works at the Pōhutukawa Unit. Dr Duff is currently the Responsible Clinician for Mr C and was previously the Responsible Clinician for Mr M before his transition to community care.

[38] The third group of witnesses gave evidence relating to the Haumietiketike Unit at Ratonga-rua-o-Porirua in Wellington, where all the applicants have at one point or another been detained and where Mr S remains, in a step-down cottage. The witnesses in that group were:

(a) Dr Justin Barry-Walsh, a forensic psychiatrist who was Mr S's Responsible Clinician on and off for a number of years;

(b) Mr Nigel Fairley who was, until recently, the Clinical Director at the Regional Forensic Mental Health Services, also known as Porirua Hospital or Ratonga-rua-o-Porirua;

(c) Dr Anthony Duncan who as well as having held the posts already mentioned, is also a forensic psychiatrist and has previously been one of Mr S's Responsible Clinicians;

(d) Dr Nick Judson, who was, at various times, and is presently Mr S's Responsible Clinician; and

(e) Mr Paul Oxnam who is a clinical psychologist who worked with Mr S for a number of years. He is presently the Clinical Leader of Intellectual Disability Services for CCDHB and has been instrumental in devising and implementing the internationally acclaimed "Stepping Stones" programme.

[39] In addition to those three groups of witnesses, the respondents also called Ms Louisa Medlicott, a clinical psychologist as an expert witness. Ms Medlicott

undertook a comprehensive review of the documentation and interviewed the applicants. Her evidence was careful, thorough and understated. I found it substantially helpful on a number of issues.

Site visits

[40] After the delivery of the applicant's opening submissions, the Court and counsel undertook site visits to both Haumetiketike at Porirua (where Mr S still lives) and Pōhutukawa at the Mason Clinic in Auckland (where Mr C still lives). We were shown around the facilities by Dr Duncan (at Porirua) and Dr Duff (in Auckland). They were also able to answer questions. I did not meet either Mr S or Mr C. The visits were extremely useful in terms of general orientation and understanding and also in terms of certain specific aspects of the claims.

Alleged unfairness of the proceeding

[41] Mr Ellis at one point submitted that it was impossible for the applicants effectively to bring a proceeding challenging their detention and the conditions of detention, because there is an insurmountable power imbalance between them and the DHBs.

[42] Although I necessarily acknowledge that the respondents are comparatively well resourced, I do not accept that the proceedings were unfair. The respondents made every possible additional accommodation to facilitate the applicants' claims. As well as the matters already noted above (in relation to the applicants' evidence):

(a) clinicians made themselves available to speak with Dr Webb in the preparation of her expert evidence; and

(b) the respondents provided extensive evidence on all issues raised by the claim, notwithstanding the deficiencies in the pleadings and notwithstanding that many of those issues were not addressed or supported by expert or other evidence called by the applicants themselves.

RELEVANT LEGISLATION

The criminal justice gateways to the detention of those with intellectual disability

[43] Between 1985 and 2004, part 7 of the CJA conferred powers on the Courts in relation to a person who was charged with imprisonable criminal offending but was "under disability". By virtue of s 108 of the CJA, a person was "under disability" if, because of the extent to which that person was "mentally disordered", that person was unable (a) to plead; or (b) to understand the nature or purpose of the proceedings; or (c) to communicate adequately with counsel for the purposes of conducting a defence. The decision was made by a Judge, on the evidence of two specialists who provided reports to the Court.

[44] Up until 1992, the term "mentally disordered" had been specifically defined in the Mental Health Act 1969 (the MHA) to include intellectual disability.[17] So when a Court was confronted by an alleged offender who appeared to be intellectually disabled it could order that the person be detained for the purpose of preparing a psychiatric report to determine whether he or she was under disability.[18] If a finding of disability was made, the Court was then provided with alternative dispositional options.

[45] More specifically, s 115 of the CJA authorised a Court to order that a mentally disordered offender be detained in a hospital as a special patient or, if the Court was satisfied on the basis of medical evidence that it would be safe in the interests of the public to do so, it could make an order that the person be detained in a hospital as a patient or immediately released.

[46] If the person was to be detained as a special patient, the criminal proceedings were not stayed and could, in certain circumstances, and within specified time frames be reactivated.[19]

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17 The relevant part of the definition would now be regarded as infelicitously phrased, but read "Mentally subnormal—that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind".

18 CJA s 121.

19 CJA s 116(4) and (6)(a), discussed further in relation to the ninth cause of action, below.

[47] If an order was made that the person be detained as a patient, then the relevant criminal proceedings were permanently stayed.[20]

[48] But when, in 1992, the MHA was repealed and replaced by the MHCAT Act that Act contained a new definition of "mental disorder":

> … an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition,[21] of such a degree that it—
>
> (a) poses a serious danger to the health or safety of that person or of others; or
>
> (b) seriously diminishes the capacity of that person to take care of himself or herself [.]

[49] This new definition did not cover people with an intellectual disability, unless they also had a mental disorder. But for alleged offenders who did fall within this narrower definition, the available options were more or less as before.

[50] The effective exclusion of people with intellectual disability *simpliciter* from the MHCAT Act appropriately recognised that intellectual disability involves limitations in intellectual functioning, rather than a mental illness. But the exclusion also left a legislative lacuna as far as intellectually disabled offenders were concerned. This resulted in some such people being inappropriately detained in prison or within the mental health services, or discharged into the community.

The CPMIP Act and the IDCCR Act

[51] This lacuna was eventually filled in 2003 with the dual enactment of the CPMIP and the IDCCR Acts.[22]

[52] Section 3 of the CPMIP Act provides that its purpose is:

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20 CJA s 116(7).

21 Disorders of cognition are typically associated with organic brain dysfunction arising, for example, from drug-related delirium, head injury, severe depression or dementia and usually involve disruption of the formal mechanisms of thought such as memory, judgment and insight. "Volition" has no clear psychiatric meaning although the Ministry of Health Guidelines to the MHCAT Act (November 2012) indicate that it will include: catatonic excitement or withdrawal; depressive stupor; passivity phenomena and command hallucinations; and a motivational syndrome found in the major psychoses.

22 Although enacted in 2003, the two Acts did not come into force until 2004.

> … to restate the law formerly set out in Part 7 of the Criminal Justice Act 1985 and to make a number of changes to that law, including changes to—
>
> (a) provide the courts with appropriate options for the detention, assessment, and care of defendants and offenders with an intellectual disability:
>
> (b) provide that a defendant may not be found unfit to stand trial for an offence unless the evidence against the defendant is sufficient to establish that the defendant caused the act or omission that forms the basis of the offence:
>
> (c) provide for a number of related matters.

[53] As s 3 makes clear, the CPMIP Act speaks in terms of offenders who are "unfit to stand trial" rather than "under disability". The "unfitness" threshold is defined in the same way as the earlier "disability" threshold except for the crucial use of the term "mental impairment" rather than "mental disorder". Although "mental impairment" is not defined in the CPMIP Act itself, it is plainly (on both a literal and purposive interpretive approach) wide enough to encompass intellectual disability.[23]

[54] As s 3 also indicates, the CPMIP Act provides that a defendant cannot be found to be unfit to stand trial unless the Court is satisfied on the balance of probabilities that he or she caused the act or omission that forms the basis of the offence with which he or she has charged.[24]

[55] Although the CPMIP Act repealed Part 7 of the CJA, it did not repeal the MHCAT Act, which continued to apply to:

> (a) those offenders who are a mentally impaired but not intellectually disabled; and
>
> (b) those intellectually disabled offenders who, by virtue of a co-existing mental disorder have, prior to 2004, been detained as special patients or patients (and are subject to compulsory treatment orders) under the MHCAT Act.

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[23] The term "intellectual disability" itself is defined in the IDCCR Act, and is set out later, below.
[24] Section 9.

[56] The dispositional options available to the Courts under ss 24 and 25 of the CPMIP Act when dealing with mentally impaired offenders are similar to those that were available under s 115 of the CJA in relation to offenders who were mentally disordered. The principal difference is that a Court confronted by an intellectually disabled person who is charged with an imprisonable offence can order him or her to be detained as a "special care recipient" under the IDCCR Act.[25] Such an order can only be made if the Court is satisfied such an order is necessary "in the interests of the public or any person or class of person who may be affected …".[26]

[57] The other important difference is that the principal alternative dispositional option is no longer that the person be "detained" as a patient under the MHCAT Act but rather that the person be "treated" as either a patient under that Act or as a "care recipient" under the IDCCR Act. While s 26 of the CPMIP Act deems such an order to be either a compulsory treatment order (under the MCHAT Act) or a compulsory care order (under the IDCCR Act) it leaves to the Court the determination whether:

(a) the compulsory treatment order takes effect as a community treatment order or as an inpatient order; or

(b) the compulsory care order will require the defendant to be detained in a secure facility or not.

[58] I interpolate at this point that notwithstanding the new terminology just noted, I propose to use the term "patient" rather than "care recipient" when referring to the applicants in this case. That is not intended to signify anything in particular other than a desire for consistent descriptors and the fact (discussed more fully below) that Mr S and Mr C have always been detained under the MHCAT Act, not the IDCCR Act.[27]

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25 CPMIP Act s 24. The parallel power to order detention of mentally disordered persons as a "special patient" under the MHCAT Act remains.

26 CPMIP Act, s 24(1)(c).

27 Mr M was transferred from being a patient under the MHCAT Act to being a care recipient under the IDCCR Act, although that only occurred at a relatively late stage in his detention.

[59] So as the foregoing discussion already makes clear, the IDCCR Act was intended to work in tandem with the CPMIP Act and in parallel with the MHCAT Act. The stated purposes of the IDCCR Act are:[28]

> (a) to provide courts with appropriate compulsory care and rehabilitation options for persons who have an intellectual disability and who are charged with, or convicted of, an offence; and
>
> (b) to recognise and safeguard the special rights of individuals subject to this Act; and
>
> (c) to provide for the appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system, remain subject to this Act.

[60] The term "intellectual disability" is defined in s 7(1) as meaning a permanent impairment that:

> (a) results in significantly sub-average general intelligence; and
>
> (b) results in significant deficits in adaptive functioning, as measured by tests generally used by clinicians, in at least 2 of the skills listed in subsection (4); and
>
> (c) became apparent during the developmental period of the person.

[61] And ss 7(3) and (4) elaborate that:

> (3) For the purposes of subsection (1)(a), an assessment of a person's general intelligence is indicative of significantly sub-average general intelligence if it results in an intelligence quotient that is expressed—
>
> (a) as 70 or less; and
>
> (b) with a confidence level of not less than 95%.
>
> (4) The skills referred to in subsection (1)(b) are—
>
> (a) communication:
>
> (b) self-care:
>
> (c) home living:
>
> (d) social skills:
>
> (e) use of community services:

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[28] IDCCR Act, s 3.

(f) self-direction:

(g) health and safety:

(h) reading, writing, and arithmetic:

(i) leisure and work.

[62] There are statutory mechanisms by which an intellectually disabled patient detained under the MHCAT Act can be transferred into the IDCCR Act regime.[29]

Compulsory treatment and compulsory care

Compulsory treatment under the MHCAT Act

[63] As noted above:

(a) s 44 of the MHCAT Act provides that where an order is made under either s 115(1) of the CJA or s 24(2) of the CPMIP Act that a person should be detained as a special patient, the person subject to that order is required be given "such care, treatment, training, and occupation" as if subject to a compulsory treatment order under that Act;

(b) s 116(4)(A) of the CJA deems an order made under s 115(2) of the CJA that the person be detained as a patient, to be a compulsory treatment order under the MHCAT Act;

(c) s 26 of the CPMIP Act deems an order made under s 25 of the CPMIP Act that the person be treated as a patient to be a compulsory treatment order under the MHCAT Act.

[64] Compulsory treatment orders under the MHCAT Act are of two kinds:[30]

(a) a community treatment order; or

(b) an inpatient order.

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29 See for example s 47A of the MHCAT Act.
30 MHCAT Act s 28.

[65] Obviously, where a court has ordered under the CJA or the CPMIP Act that a person be "detained" as a special patient or as a patient he or she will be treated as if he is subject to an inpatient order. But where an order is made under s 25(1) of the CPMIP Act an inpatient order may only be made where the court considers that the patient cannot be treated adequately as an outpatient.

[66] An inpatient order requires the patient to be detained in a specified hospital for the purposes of treatment and "shall require the patient to accept treatment".[31]

[67] A compulsory patient must accept treatment during the compulsory assessment period, and during the first month of the order. At any other time, a compulsory patient may only be treated by consent, or if consent cannot be obtained, in accordance with a second opinion given by an appointed psychiatrist. There is no power under the MHCAT Act to provide any other form of medical treatment.

Compulsory care under the IDCCR Act

[68] Under the IDCCR Act a special care recipient is liable to be detained in a secure facility. A secure facility is any place used to provide care to persons with intellectual disability with particular features designed to prevent a patient leaving that facility. Those who are not special care recipients can be made subject to either secure orders or supervised care orders. For those who are no longer subject to the criminal justice system, secure care can only be ordered if the Family Court considers supervised care poses a serious danger to the health or safety of the care recipient or others.[32]

[69] Under s 47 a care recipient must accept the care properly given to him or her under the court order or the care plan. Care recipients are required to comply with every lawful direction given by his or her co-ordinator or care manager.

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31 MHCAT Act s 30. "Hospital" means premises used to provide hospital mental health care in terms of the Health and Disability Services (Safety) Act 2001 (HDSSA).

32 IDCCR Act s 45(3).

Duration of orders

Special patients and special care recipients

[70] Where a person is unfit to stand trial and an order has been made under either s 115 of the CJA or s 24 of the CPMIP Act that he or she is to be detained as a special patient under the MCHAT Act or as a special care recipient under the IDCCR Act, then he or she may only be detained as such pursuant to that order for up to half of the maximum sentence on the charge which led to the making of the order for detention.[33]

[71] If, at the expiry of half the maximum sentence, a certificate under the MHCAT or the IDCCR has been given to the effect that the person has become fit to stand trial, he or she may, at the direction of the Attorney-General:[34]

(a) be returned to court to face the original charge; or

(b) be held as a patient (under the MHCAT Act) or as a care recipient (under the IDCCR Act).

[72] If the special patient/special care recipient remains unfit to stand trial at the expiry of half the maximum sentence, and no other change of status has been ordered in the interim, the Attorney-General must direct that the person is then to be held as a patient or a care recipient.[35] Such a direction is then deemed to be a compulsory treatment order or a compulsory care order as the case may be.[36]

[73] In short, after the expiry of half the maximum sentence for the qualifying original offence, a special patient or a special care recipient will (one way or another) no longer be "subject to the criminal justice system". Any order for their continued detention (as a patient or a care recipient) will be civil in nature.

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33 CJA, s 116(1); CPMIP Act, s 30. If the charge was punishable by life imprisonment then the relevant maximum detention period is 7 years under the CJA or 10 years under the CPMIP Act.

34 CJA, s 116(4); CPMIP Act, s 31(2).

35 CJA, s 116(6)(b); CPMIP Act, s 31(4).

36 CJA, s 116(6A); CPMIP Act, s 31(5).

Patients subject to compulsory treatment orders under the MHCAT Act

[74] If a person is detained as a patient pursuant to a compulsory treatment order under the MHCAT Act:

(a) the order expires after six months;[37] but

(b) if the responsible clinician conducts a review under s 76 within 14 days of the expiry date and is satisfied that compulsory status should continue then he or she may apply to the Family Court for a six month extension of the order;[38]

(c) in determining such an application the Family Court the patient has a right to be heard, represented and to call evidence;[39]

(d) at the expiry of the first six month extension a further extension application can be made which, if granted, has effect indefinitely, unless and until the patient is released from compulsory status.[40]

[75] Notwithstanding that, if a patient's responsible clinician considers a patient is fit to be released from compulsory status he or she may so direct at any time.[41]

Those subject to compulsory care orders under the IDDCR Act

[76] Every care recipient must have a care and rehabilitation plan[42] and there is a system providing for regular reviews of that plan. Reviews are initiated by a patient's compulsory care co-ordinator.[43]

[77] There is also a requirement for regular six-monthly reviews of a care recipient's condition by one or more specialist assessors to ensure that there is a continued need

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37 MHCAT Act, s 33.
38 Section 34(2).
39 The Part 2 processes are incorporated by virtue of s 34(3).
40 Section 34(4).
41 Section 35.
42 IDCCR Act, ss 24-28.
43 Section 72. Compulsory care co-ordinators are appointed by the Director-General of Health under s 140 of the Act.

for compulsory care.[44] If the assessor takes the view that there is no continued need for compulsory care the care co-ordinator can (on the advice of the specialist assessor) apply to the Family Court for the cancel a compulsory care order.[45]

[78] One key difference between compulsory treatment orders under the MHCAT and orders under the IDCCR Act is that compulsory care orders under the latter Act are always finite and may not be for a period of longer than three years (although they can be renewed).[46] Expiry can be deferred when an application to renew is pending.[47]

Oversight mechanisms

Rights of review: MHCAT Act

[79] For so long as a compulsory treatment order is in force, the responsible clinician is required to undertake a six monthly review, after which he or she must produce a certificate of clinical review setting out whether or not the patient is fit to be released from compulsory status.[48]

[80] After a certificate of clinical review has been completed, any person to whom the certificate is sent may apply to the Mental Health Review Tribunal (MHRT) for a review of the patient's condition.[49] District Inspectors are specifically charged with reviewing such certificates and reports.[50] They discuss them with the patient and then decide whether an application should be made the MHRT for a review of the compulsory treatment order.[51] The MHRT's jurisdiction is limited to a consideration of whether a patient is fit to be released from compulsory status.[52] It cannot make

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44 Sections 77-79.
45 Section 84.
46 Section 46(2).
47 Section 87.
48 MHCAT Act section 76(3). If the outcome of the review is that the patient is not fit to be released, s 76 requires the certificates to be sent to (inter alia) the patient, his or her welfare guardian, a District Inspector and an official visitor.
49 Section 79.
50 District Inspectors and official visitors are appointed by the Minister of Health under s 94 of the MHCAT Act. Their role under that Act (and under the IDCCR Act) is discussed in more detail later, below.
51 Section 76(9)-(11).
52 Section 79(7).

recommendations as to the appropriateness of a patient's treatment. There is a right of appeal from the MHRT to the District Court.[53]

[81] Section 84 of the MHCAT Act also provides for patients to apply for an inquiry into various matters by a High Court Judge.

[82] Special patients have all the same review rights as compulsory patients, but there are different processes for clinical review and MHRT consideration, due to the continuing interaction with the CPMIP Act. More particularly, in the case of a special patient who was ordered to be detained following a finding of unfitness to stand trial, s 77(3) provides:

> (a) at the conclusion of the review, the responsible clinician shall record his or her findings in a certificate of clinical review in the prescribed form, stating—
>
> (i) that in his or her opinion the patient is no longer unfit to stand trial; or
>
> (ii) that in his or her opinion the patient is still unfit to stand trial but it is no longer necessary that the patient should be subject to the order of detention as a special patient; or
>
> (iii) that in his or her opinion the patient is still unfit to stand trial and should continue to be subject to the order of detention as a special patient:

[83] The link with the Attorney-General's functions under the CPMIP Act is made clear later in the subsection:

> (c) in any case where the responsible clinician is of the opinion that the patient is no longer unfit to stand trial, or that the patient is still unfit to stand trial but it is no longer necessary that the patient should be subject to the order of detention as a special patient, that clinician shall also send a copy of the certificate of clinical review to the Attorney-General for the purposes of section 31 of the Criminal Procedure (Mentally Impaired Persons) Act 2003:
>
> (d) despite section 31 of the Criminal Procedure (Mentally Impaired Persons) Act 2003, on receiving a copy of the certificate of clinical review under paragraph (c), the Attorney-General may, instead of exercising and performing the powers and duties under that section, apply to the Review Tribunal for a review of the patient's condition.

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[53] Section 83.

Rights of Review: the IDCCR Act

[84] There are broadly similar provisions in the IDCCR act. That Act requires that, following each six monthly review, the specialist assessor must produce a certificate as to whether or not the patient is fit to be released from compulsory status.[54] That certificate is required to be forwarded to (inter alia) the care recipient him or herself, his or her welfare guardian and lawyer (if any) and the responsible District Inspector.[55]

[85] As well as the extensive powers of investigation and inquiry conferred by the IDCCR Act on District Inspectors, the Act also confers examination, inquiry and reporting powers on the High Court, which may be initiated at the Court's own motion or on the application of any person.[56]

[86] As under the MHCAT Act, there are specific provisions dealing with status reviews of special care recipients (again, due to the continued interaction with the CPMIP Act).[57]

Rights and complaints: MHCAT Act

[87] Patients retain all their usual rights, so far as they are compatible with compulsory treatment under the Act. Patients also have a range of special rights, outlined in Part 6, which provide minimum standards for compulsory hospital detention. These include the rights to:[58]

(a) be initially informed, and then kept informed, of the person's rights as a patient, including legal status, the procedures for initiating a review of the compulsory treatment order or the conditions of their treatment, and the functions and duties of District Inspectors;

(b) respect for cultural identity;

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54 IDCCR Act s 79.
55 Sections 80 and 81.
56 Sections 102–107.
57 Sections 89–94.
58 MHCAT Act ss 64–74.

(c) medical treatment and health care appropriate to the person's condition;

(d) be informed about the nature and side-effects of treatment prior to its commencement;

(e) seek independent legal and psychiatric advice;

(f) enjoy the company of others unless seclusion is necessary for the care or treatment of the patient, or for the protection of other patients; and

(g) receive visitors, make phone calls, and send and receive letters and postal articles.

[88] Section 75 of the MHCAT Act establishes a complaints process. Complaints are made to either a District Inspector or an Official Visitor in the first instance.

Rights and complaints: IDCCR Act

[89] The procedural protections and the special rights of people subject to orders under the IDCCR Act are very similar to those under the MHCAT Act. Rights materially identical to those just listed are contained in subpart 1 of Part 5 of the Act.

[90] As well, s 48 specifically states that care recipients are "consumers" under the Code of Health and Disability Services (the Code).[59] That Code confers rights on consumers, and imposes obligations and duties on the providers of health and disability services.

[91] As well s 11, sets out the principle which is to govern the exercise of all powers under the Act as follows:

> Every court or person who exercises, or proposes to exercise, a power under this Act in respect of a care recipient must be guided by the principle that the care recipient should be treated so as to protect—
>
> (a) the health and safety of the care recipient and of others; and

[59] Although the MHCAT Act does not make this express, it is clear that patients are also consumers in terms of the Code. The evidence was that on admission to the service all patients or care recipients receive a copy of their rights under the Code,

(b) the rights of the care recipient.

[92] And in *RIDCA Central v VM* the Court of Appeal said of this section:[60]

> [35] The reference to the rights of a care recipient in s 11(b) is not specific as to which rights are being referred to, and there is no reason to read it down in any way. The IDCCR Act itself sets out a number of rights applying to care recipients or proposed care recipients, such as the right to legal advice and the right to information. There are many others. However, we think the focus of the principles set out in s 11(b) is on more fundamental rights, particularly rights ensuring basic freedoms of the kind described in the New Zealand Bill of Rights Act 1990 (the Bill of Rights) such as the right to freedom of movement, the right not to be arbitrarily arrested or detained, and the right to be free from discrimination on the grounds of disability. In a similar context, the Supreme Court of Canada used the phrase "liberty interest" to describe these rights and we will adopt the same term.

DHB complaints procedures

[93] Both DHBs have comprehensive complaints policies and procedures. Patients are made aware of their right to complain and about the complaints procedure through information available at all facilities (including by way of posters, leaflets and feedback forms). This information is also available to patients' families and advocates, who can initiate complaints on behalf of clients. Simple complaint forms are made available to initiate complaints. Evidence about the WDHB's complaints management policy and process was given by Dr Skipworth. Evidence about the CCDHB's complaints policy and process was given by Mr Fairley.

District Inspectors

[94] I have mentioned District Inspectors already. They are barristers and solicitors appointed under either the IDCCR Act or the MHCAT Act, or both.[61] They provide independent legally mandated oversight of the general operations of forensic Units such as Haumietiketike and Pōhutukawa. They are tasked with ensuring that patients are advised of their rights, and that complaints are investigated and acted upon where required.

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60 *RIDCA Central v VM* [2011] NZCA 659.

61 All IDCCR Act District Inspectors are also authorised under the MHCAT Act (although the opposite is not true).

[95] In the case of patients detained pursuant to the MHCAT Act District Inspectors have the following general functions:

(a) provision of information and checking of documentation;

(b) ensuring that throughout the assessment process the proposed patient or patient is aware of his or her rights and is able to facilitate an early review of his or her detention if appropriate;

(c) attendance at Court or MHRT hearings concerning patients;

(d) visiting and inspecting (at least monthly) each of the hospitals and services in their region in which a patient is being assessed or treated under the Act; and

(e) investigating and resolving complaints about breaches of rights relating to care and treatment under the Act.

[96] Section 95 of the Act provides that they have all the powers of a Commission of Inquiry.

[97] And as I have already mentioned, if, after a six month review, the responsible clinician certifies that the patient is not fit to be released from compulsory status and the patient or their family disagrees, the District Inspector can facilitate the referral of the case to the MHRT.[62] The District Inspector also has a power to refer the case to the MHRT in certain circumstances even if the patient does not wish such a referral to be made.[63]

[98] District Inspectors have an almost identical role under the IDCCR Act, except that their power to investigate breaches of rights is slightly more limited (and there is no right of review by the MHRT).[64]

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62 Section 76(9) and (10).
63 Section 76(11).
64 IDCCR Act, Part 7, Subpart 1.

The Mental Health Review Tribunal

[99] The MHRT provides oversight of the status of patients subject to the MHCAT Act. The Tribunal's functions include:

(a) deciding whether patients are fit to be released from compulsory status;[65]

(b) making recommendations about the status of special patients;[66]

(c) considering the status of restricted patients;[67]

(d) investigating complaints about breaches of patient rights;[68]

(e) appointing the psychiatrists who give second opinions about patient treatment;[69]

(f) appointing the psychiatrists who decide whether electro-convulsive treatment is in the interests of patients.[70]

The Health and Disability Commissioner

[100] The Health and Disability Commissioner receives and investigates complaints of breaches of the Code. As I have said, all patients detained in the Units are Health and Disability Services Consumers. Services must be provided to them consistently with the Code unless those rights are expressly overridden by either the MHCAT Act or the IDCCR Act.

[101] If, on a complaint by a consumer, the Commissioner finds that his or her rights under the Code have been breached, he or she may refer the provider to the Director of Proceedings,[71] who has responsibility for pursuing cases in either the Health

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65 MHCAT Act, s 79.
66 Section 80.
67 Section 81.
68 Section 75(4).
69 Section 59(2)(b).
70 Section 60(b).
71 Health and Disability Commissioner Act 1994, s 45(2)(f).

Practitioners Disciplinary Tribunal (if the subject of the complaint is a registered health practitioner) or the Human Rights Review Tribunal.[72]

The Ombudsman/NPM

[102] In 2007, the New Zealand Government ratified the Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT's objective is to establish a system of regular visits by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment. In New Zealand the designated independent body (called the National Preventive Mechanism or NPM) for hospitals and secure facilities is an Ombudsman holding office under the Ombudsmen Act 1975.

[103] The NPM's functions, in respect of places of detention, include:[73]

> (a) to examine the conditions of detention applying to detainees and the treatment of detainees; and
>
> (b) to make any recommendations it considers appropriate to the person in charge of a place of detention:
>
> (i) for improving the conditions of detention applying to detainees;
>
> (ii) for improving the treatment of detainees; and
>
> (iii) for preventing torture and other cruel, inhumane or degrading treatment or punishment in places of detention.

[104] An NPM can visit, at regular intervals or at any other time any place of detention for which it is designated. Ms Daysh gave evidence that the Ombudsman conducts announced or unannounced inspections of facilities. In the course of those inspections, the Ombudsman will often meet with patients and he also has a "watching

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72 Section 49.
73 Crimes of Torture Act 1989, s 27.

brief" in relation to certain specific patients. As well, family members may raise concerns directly with the Ombudsman.

[105] When an NPM visit is in prospect, the Inspector may request some information beforehand and request that other information be provided at the time of the visit.

[106] At the commencement of each site visit, there will normally be a meeting with the manager of the unit, or that person's delegate, during which the Inspector will indicate how the visit should proceed. During the visit, informal interviews and discussions will be undertaken with staff and one or more of the patients, and a tour of the facility, preferably in its entirety, should take place.

[107] Because of the wide scope of issues which may be considered by the NPM, it is sometimes not possible to address them all during each visit. Visits may therefore focus on specific geographical areas or rooms, certain kinds of facilities or on the documentary record.

[108] Visits will be followed by a report which will include findings and recommendations (if any) aimed at improving the treatment and conditions of detention of persons deprived of their liberty. Implementation of any recommendations will be closely monitored.

[109] It is relevant to the present case that both Haumietiketike and the Pōhutukawa Units have, from time to time, been audited by the Ombudsman in her role as NPM.

[110] On 30 September 2008 an Inspector visited the Haumietiketike Unit. The Inspector:

(a) found no evidence that the patients in the unit had been subjected to torture or any other cruel or inhuman treatment; and

(b) was satisfied that there were adequate systems and processes in place to ensure clients detained within the unit were not subjected to cruel, inhuman or degrading treatment or punishment. The Ombudsman had no recommendations to make.

[111] On 23 January 2014, an Inspector visited the Haumietiketike Unit again. The Inspector's findings can be summarised as follows:

(a) the interactions observed between staff and patients were respectful, encouraging and appropriate;

(b) patients in the Unit have no problems communicating with family and friends, either during a visit or through the telephone/mail;

(c) patients have access to daily fresh air;

(d) there is a comprehensive activities programme for both individuals and groups;

(e) most clients appear to spend a considerable amount of time out of the Unit;

(f) there seemed to be no issues with the complaints system and patients are able to contact the District Inspectors directly;

(g) generally, seclusion and restraint paperwork was of a good standard;

(h) there are adequate bathroom facilities in the Unit;

(i) patients have access to clean bedding and clothing;

(j) there were no complaints about the quality or quantity of food; and

(k) there was no evidence that any patient had been subject to any actions amounting to torture in the six months preceding the visit.

[112] Issues identified as needing addressing were:

(a) the use of seclusion rooms as bedrooms;[74]

[74] The evidence (which I accept) was that this comment related to two particular patients, neither of

(b) not all staff were up to date with their restraint training refresher course; and

(c) although the Unit was clean and tidy, it was looking a little tired in places, especially the de-escalation area.

[113] The Pōhutukawa Unit was the subject of an inspection in 2012. The subsequent report by the Ombudsman recorded that:

(a) there was no evidence that any patients had been subject to torture or cruel, inhuman or degrading treatment in the six months preceding the visit;

(b) the Inspectors had no issues of concern arising from the use of seclusion and restraint in the Unit;

(c) there were no written complaints for the Unit in the six months prior to the visit;

(d) the standard of record keeping in the Unit was good;

(e) the Unit was highly organised, clean, tidy and well maintained;

(f) the Inspectors had no concerns with the level of outdoor exercise care recipients could access;

(g) there was a great activities programme which patients could utilise if they wished;

(h) primary health care services were available to all patients;

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whom are applicants in these proceedings. He said that those arrangements were in response to very particular difficulties encountered with those patients and, at the time of the report's publication, alternative accommodation had been found and the patients had been relocated.

(i) there was a "positive feel" to the place with some very enthusiastic staff trying to make a difference, in what could sometimes be described as very difficult circumstances.

[114] The Ombudsman had no recommendations to make, but noted that an information booklet/pamphlet about the Unit would be useful for the patients, families and visitors.

The Human Rights Commission

[115] The Human Rights Commission has a specific role to ensure that the human rights of those with disabilities are respected and maintained. Like the Ombudsman, the Human Rights Commission is one of the three "independent mechanisms" charged with monitoring and reporting on the implementation of the CRPD.[75] The Commission's role is to promote the rights of people with disabilities and to actively monitor and report on compliance with the Convention. This work is led by the Disability Rights Commissioner.

Standards, audits and guidelines

[116] General standards for health and disability support services are made by the Minister of Health under s 13 of the HDSSA. The HDSSA promotes the safe provision of health and disability services through the promulgation of standards and an associated certification and audit process. The minimum content of standards is not specified, but the Act does authorise certain forms of standard (for example, statements of appropriate outcomes, technical specifications for equipment, and minimum staffing requirements).[76] The Minister is required to commence a review of the standards no later than four years following their introduction or amendment or, in the absence of amendment, from the date the previous consultation began.[77]

[117] The New Zealand *Health and Disability Services (Core) Standards* (the *Core Standards*) deal with everything from the condition of the physical facilities, to

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75 The other being the New Zealand Convention Coalition (a national group of disabled people's organisations).
76 HDSSA, s 21.
77 Section 24.

management structures and processes, consumer rights, reporting requirements, medication management, staff training and nutrition and fluid management.

[118] For example Core Standard 3.6 provides:

> **Standard 3.6 Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.**
>
> … The criteria required to achieve this outcome shall include the organisation ensuring:
>
> 3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.
>
> 3.6.2 Appropriate links are developed and maintained with other services and organisations working with consumers and their families.
>
> 3.6.3 The consumer receives the least restrictive and intrusive treatment and/or support possible. (MHA)[78]
>
> 3.6.4 The consumer receives safe and respectful services in accordance with current accepted good practice, and which meets their assessed needs, and desired outcomes.
>
> 3.6.5 The consumer receives services which: (MHA)
>
> (a) Promote mental health and well-being;
>
> (b) Limit as far as possible the onset of mental illness or mental health issues;
>
> (c) Provide information about mental illness and mental health issues, including prevention of these;
>
> (d) Promote acceptance and inclusion;
>
> (e) Reduce stigma and discrimination. This shall be achieved by working collaboratively with consumers, family/whanau of choice if appropriate, health, justice and social services, and other community groups.

[119] The Core Standards require that the Units in which the applicants have resided be certified by the Ministry of Health as complying with the standards, and each Unit is audited against them on a regular basis. Audits are also conducted to ensure compliance with the. Ministry of Health's service standards. The Ministry's audits can be with or without notice. Certification audits must occur at least every three years.

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[78] MHA means the standard applies only to mental health and addictions services.

[120] Other relevant Standards promulgated under the HDSSA include the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards, which specifically deals with all forms of restraint and seclusion. I address these in more detail later in this judgment.

[121] The MHCAT Act and the IDCCR Act also make provision for the promulgation of guidelines and standards:

(a) the Director-General of Health may promulgate standards and guidelines under s 130 MHCAT Act and s 148(1) IDCCR Act; and

(b) the Director-General must ensure that guidelines relating to the use of seclusion and prescribing of medication for care recipients are promulgated under s 148(2) IDCCR.

FACILITIES FOR OFFENDERS WITH INTELLECTUAL DISABILITIES

[122] Ms Medlicott explained that, historically, many people with mental health, physical or intellectual disabilities were cared for in large institutions. In places such as Seacliff near Dunedin, patients lived in communal wards with 40 or more people sleeping in one dormitory, sharing communal clothes, and often having baths in open bathing rooms. Those who lived in such places were often there for decades, and many remained there for their entire lives. She said that while many of the staff working in the institutions provided clinical care and support that was of a good quality at the time, there were undoubtedly others who did abuse and "dominate" those who were in their care.

[123] Ms Medlicott also spoke about related concerns over the frequent use of restraint and seclusion in such institutions, particularly before the 1950s, due to the unavailability of psychotropic medications (the first antipsychotic medication, Chlorpromazine, was not discovered until the end of 1951). Although, from that point on the benefits of such medications in treating the symptoms psychosis were

recognised, their less desirable side-effects also led to their significant use for the purpose simply of sedating those with challenging behaviour.[79]

[124] Disquiet about the long term impact of life in large psychiatric institutions first began to be expressed in the 1940s. The over-use of psychotropic medication became of increasing concern in the 1980s. Internationally, the move to "deinstitutionalisation" was marked by the passage of the Danish Mental Retardation Act 1959 which aimed "to create an existence for the mentally retarded as close to normal living conditions as possible." In New Zealand, Cherry Farm near Dunedin was the first of the large institutions to close, in November 1992. The last major institution to shut its doors was Kimberley near Levin, in 2007.

[125] At the same time as the closure of these institutions was occurring, the rights of those with mental health issues and intellectual disabilities were increasingly recognised. The NZBORA was passed in 1990, the MHCAT Act was passed in 1992, the Privacy and the Human Rights Acts were passed in 1993, and the Health and Disability Commissioners Act was passed in 1994. Each of these statutes contained provisions which promoted and protected the rights of people who had contact with the mental health system.

[126] Despite such significant societal shifts, there has continued to be a need for hospital based treatment and rehabilitation for a small number of individuals with mental health disorders or intellectual disabilities who present with significant clinical difficulties and who pose significant risks to themselves or to others. Ms Medlicott said that specialized hospital services for those with intellectual disabilities now tend to take the form of small units (such as the ones in which the applicants have lived) usually housing no more than 15 patients at a time. They have high staff to patient ratio with a clear focus on addressing the reasons why such people are in hospital care, through thorough constant assessment, treatment, and review processes. She said a significant amount of clinical expertise goes into helping each person in the units to move towards having a good quality life in the community while at the same time keeping both the patients themselves and staff safe.

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[79] This is known as "chemical restraint" and is discussed later in this judgment.

[127] Ms Daysh's evidence was that in New Zealand today there are approximately 32,000 people access funded Disability Support Services each year. Included in these are the services provided by the CCDHB and WDHB for the small group of people (such as the applicants) who have intellectual disabilities and are compulsorily detained after having been found unfit to stand trial, or having been convicted of a criminal offence, and who present a high risk to themselves and others. She said that at present, there are about 130 intellectually disabled people detained in that way. That is about 0.4 per cent of the number of people who receive Disability Support Services annually.

The Units

[128] Prior to the commencement of the IDCCR Act in 2004 there were no residential forensic facilities dedicated simply to those offenders with intellectual disabilities. So those such as the applicants (who were both intellectually disabled and mentally disordered) were accommodated in mental health forensic units alongside other offenders of "normal" intelligence but who were mentally disordered. For obvious reasons, this could be less than satisfactory.

Wellington

[129] For the CCDHB, forensic inpatient services are housed in buildings on the grounds of the former Porirua Hospital. In October 1999 a temporary mental health forensic unit called Te Huia opened. Patients in that Unit came from Stanford House (the forensic unit in Whanganui Hospital). They included Mr S who was first admitted to Te Huia on 19 October 1999.

[130] In September 2001, the complex known as Ratonga-Rua-o-Porirua, which replaced Porirua Hospital, opened. The secure mental health forensic units there are known as Pūrehurehu and Rangipapa. After those Units opened, Te Huia became the temporary forensic intellectual disability unit.

[131] At that point, intellectually disabled patients from Auckland (and other places), including Messrs M and C, transferred to Te Huia. A permanent, dedicated forensic intellectual disability Unit, Haumietiketike, opened in October 2004. After the

opening of Haumietiketike, Te Huia closed, was partly bulldozed and the remainder of the unit became a Learning and Development Centre.

[132] In April 2006, two purpose-built Lockwood cottages were opened, co-located with Haumietiketike. Those cottages are known as Whakaruru and Manawanui. They provide accommodation for patients who are part of the intellectual disability transitional service. At the time of the hearing before me Mr S was living in Whakaruru. Other facilities include Tāwhirimātea, which is a mental health rehabilitation centre, Tangaroa which is a day/activity centre and Te Maara which is the day programme centre.

Auckland

[133] For the WDHB, inpatient services are provided at the Mason Clinic at Point Chevalier. Newly admitted patients normally start in one of the acute units known as Kauri or Tōtara. These were the first units at the Mason Clinic, opened in 1992. The mental health rehabilitation units are named Rātā, Kahikatea, Tānekaha, Tāne Whakapiripiri and Rimu.

[134] The Mason Clinic's dedicated forensic intellectual disability service, the Pōhutukawa Unit was opened in 2006. That is where Mr C presently lives and where Mr M lived after his transfer from Wellington until his release from compulsory care in 2012.

Layout of Units

[135] The Units contain communal spaces such as a dining room, kitchen and 1ounges. Accommodation facilities are grouped into "clusters".

[136] The "High Care" cluster area has two bedrooms, a living area and a bathroom with a shower and toilet. This is the most secure area of the unit, where patients are taken when it is assessed that they pose a significant risk to themselves or others. It is a low stimulus environment, with minimal furnishing.

[137] The "assessment area" cluster is comprised of two bedrooms, a living area, a shower room and a toilet. The bedrooms in the assessment area have more furnishings than those in the High Care area but are more basic than those in the general clusters. There are increased security features in this area. Patients are accommodated in this area when it is assessed that they may pose some risk to themselves or others, but not to the level where they are required to be cared for in the High Care area.

[138] There are also other clusters of bedrooms with a living area, two showers and two toilets. At the Pōhutukawa Unit, there is one cluster of four bedrooms and another cluster intended to house two patients. However, given his particular needs, Mr C has had this area set aside for his exclusive use.

[139] At the Pōhutukawa Unit there is also a "rehabilitation" cluster. In this area, patients may be provided a higher level of independence, including the ability to cook their own meals. In Porirua, the equivalent is the cottages which provide a transitional level of care.

Staff

[140] At both Haumietiketike and Pōhutukawa the staff to patient ratio is usually 1:1, although there are opportunities for group activities where a patient's risk permits. There are occasions where staff ratios are higher where the patient's behaviour requires it. The provision of appropriately qualified and trained staff is required by the Core Standards, referred to above.

[141] Each patient at Haumietiketike and Pōhutukawa has a team of staff that work with him or her. Those teams are multidisciplinary, and will usually comprise a responsible clinician, psychiatric nurses (also known as key workers) a psychologist, an occupational therapist, and a social worker. While Mr M was detained at the Pōhutukawa Unit under the IDCCR Act, his care team included a care manager and a care coordinator.

[142] There are different shifts of staff during the day, and there are reduced staffing numbers at night.

[143] As I have said, the Court conducted a site visit to both Haumietiketike in Wellington and the Pōhutukawa Unit in Auckland. No evidence was given about the layout of or conditions at the places in which the applicants were detained prior to the opening of these Units.

THE APPLICANTS AND THEIR INTERACTIONS WITH FORENSIC SERVICES

[144] Because the applicants' challenge the legality of aspects of their detention and treatment between 2000 and 2012 as unlawful it is necessary to set out chronologically and in some detail when, where and on what basis they have been detained during that time. Their earlier interactions with the criminal justice and mental health systems are also included, by way of background and context.

Mr S

[145] Mr S was born on 3 February 1978 in Hawke's Bay. He spent a brief period of time in foster care, and was placed in a children's home in Greytown at the age of four. He went to Marewa Special Education Unit where he exhibited aggressive behaviour. He was referred to Hogben Special Needs School for Boys in Christchurch where he remained until 1994. While at Hogben, it was alleged that he was sexually, physically and emotionally abused by staff and peers. In 1994 Mr S went to live with his mother, half-sister and half-brother in Levin. But due to his difficult behaviour he was placed in foster care. He was transferred to the Kimberly Centre following assault charges in 1995. He had a job cutting firewood for the IHC in 1995 to 1996 but was fired from his job after assaulting a woman.

[146] On or about 2 March 1998 three charges of aggravated assault were laid against Mr S. It was alleged that he had hit three members of the public with an iron bar which he had earlier hidden in the grounds of Kimberly Hospital. He escaped from Kimberly and went to a shopping centre south of Levin. He clasped the iron bar above his head, came into the shop and struck a victim on the right shoulder causing a fracture. He next hit a woman on her wrist when she raised her hands to protect herself. She sustained a two-inch long fracture of the wrist. He ran off. The next victim was getting out of a vehicle and also raised his hands to protect himself. He was struck on his arm

and then on his left leg, receiving a bruised right arm and a puncture wound to his left hip.

[147] After the assaults, he was admitted to Stanford House (a secure facility in Whanganui). In the course of subsequent court proceedings, he was found to be "under disability" and detained in a hospital as a special patient under the MHCAT Act, pursuant to s 115(l)(a) of the CJA. He remained detained at Stanford House. His status as a Special Patient was reviewed and continued on 16 August 1999. Two months later, he transferred from Whanganui to Porirua, and was admitted to the Pūrehurehu Unit at Porirua Hospital. A month later, he transferred to the Te Huia Unit, and then was transferred back to the Pūrehurehu Unit. His status as a Special Patient was reviewed and continued on 9 February 2000.

[148] In approximately June 2000, Mr S began a programme aimed at transitioning him to the IHC Service, Tīmata Hou. Dr Nick Judson described this Service as follows:

> The service that they were running at that stage was based on a small rural property at Pauatahanui where they had a small residential unit and a day programme based on a horticultural facility so that [Mr S] was going to the day programme based at that horticultural facility with a view to most likely moving into the residence on the same site. So that was part of getting him used to their programme and their staff and the mix of people that were there.

[149] As Dr Judson went on to explain (and the records confirm), however, after Mr S moved to the residential unit, matters deteriorated and he had to return to hospital.

[150] His status as a Special Patient was reviewed and continued on 13 August 2000.

[151] On or about 12 November 2000, Mr S reached his maximum level of detention in terms of s 116 of the CJA. Based on the clinical view of his condition at that time, he was reclassified as a patient subject to a compulsory treatment order under the MHCAT Act. His status was formally changed on 7 February 2001. Attempts to assist Mr S to transition to Tīmata Hou continued during this time.

[152] On 7 May 2001 Mr S was discharged from compulsory patient status under the MHCAT Act. At that stage he became a voluntary patient.

[153] A month later, however, Mr S was admitted to Wellington Hospital after he had become assaultive at IHC and had expressed suicidal thoughts. He was readmitted to the Pūrehurehu Unit in June 2001. A compulsory treatment order was made on 24 July 2001 and Mr S was detained as an inpatient under s 30 of the MHCAT Act. A further unsuccessful attempt was made to transition Mr S to Tīmata Hou in August to October 2001.

[154] The attempts to transition Mr S to Tīmata Hou were supported by Mr S's treating clinicians who were not happy with his placement in Pūrehurehu, which also housed patients who were mentally disordered but not intellectually disabled. But, as Dr Judson recalled:

> That was just the reality. I mean at that stage the whole process of developing some more specific services and legislation around people with intellectual disability was in the process of being discussed and it was a very prolonged process of discussion that had been happening with the Ministry of Health and the DHBs about developing these services … it was going fairly slowly and I think it was a little bit frustrating so I think some of that correspondence was really trying to gee-up, let's get on with these, with the units because the reality was that there weren't any specific secure units for people with intellectual disability who needed that level of secure care or were under the kind of special patients orders like [Mr S] was so the only option at that stage was for them to be managed within the secure forensic unit alongside more able but mentally unwell patients, so it was not an ideal situation and so some of that correspondence was just trying to sort of agitate to get that process going a little faster I think.

[155] Mr S's in-patient status was reviewed and continued on 19 October 2001 and 22 January 2002. His in-patient status was extended on 29 January 2002. It was further reviewed on 26 April 2002. Throughout this time, Mr S was detained in the Pūrehurehu Unit at Ratonga-Rua-o-Porirua.

[156] On 2 July 2002, Mr S was transferred to the Te Huia Unit. His status as an inpatient was again reviewed and continued on 22 July 2002. On 27 July 2002, his inpatient treatment order was indefinitely extended, pursuant to s 34(4) of the MHCAT Act.

[157] On 13 September 2002, Mr S was charged with male assaults female. That charge arose because Mr S had, while on an outing, attempted to withdraw cash from an ATM when the machine swallowed his card. He hit the machine, then hit out at

the attending staff member. Mr S went to the Police station where he was met there by another staff member. Mr S said that he wanted the Police to arrest him. When he was told that he would not be arrested, he hit the second staff member. On 23 June 2003 and 20 April 2004 his status as a patient was reviewed and continued. He remained at the Te Huia Unit at this time.

[158] Then followed another attempt to transition Mr S to Tīmata Hou. That process began around July 2004, and he was formally discharged to Tīmata Hou in August 2004. However, he was admitted to the Tāwhirimātea Unit at Ratonga-Rua-o-Porirua on 10 October 2004 following assaults on staff at Tīmata Hou. He remained at Tāwhirimātea for just under a month, before being discharged back to Tīmata Hou. However, he was admitted to the newly opened Haumietiketike Unit on 13 December 2004 following further assaults on staff. He remained at Haumietiketike from then on.

[159] Mr S' status as an inpatient was continued on 25 May 2005. Two months later, he was again charged with male assaults female. That charge related to an incident on 27 July 2005 where he became anxious whilst in a hospital waiting room, and punched an elderly woman in the head. He was found unfit to stand trial and ordered to be held as a special patient under the MHCAT Act pursuant to s 24(2)(a) of the CPMIP Act. His status as a special patient was continued on 22 June 2006 and again on 18 December 2006.

[160] His status again changed to that of patient on 28 February 2007 following the expiry of half the maximum term of imprisonment for the male assaults female charge.[80] That status was reviewed and continued on 28 May 2007, 17 August 2007, and was extended on 21 September 2007. His status was reviewed and continued on 28 November 2007, and again on 20 February 2008.

[161] On 26 February 2008, his status as a patient under the MHCAT Act was indefinitely extended. It has since been reviewed and continued on

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[80] The maximum penalty for this offence under s 194 of the Crimes Act 1961 is two years' imprisonment.

21 November 2008, 25 May 2009, 27 November 2009, 21 May 2010, 10 November 2010, 18 May 2011, 28 November 2011, 25 May 2012, and 27 November 2012.

Presentation

[162] Dr Barry-Walsh described Mr S's complex range of psychiatric and psychological problems as follows:

> He [is] intellectually disabled. He has autism. He has bipolar affective disorder, a mood disorder. So that's a starting point. In addition to that, he had had a difficult upbringing. He had had frequent change of carers. He'd been in and out of institutions. We understand that as a child, an adolescent, he was probably exposed to significant trauma. The trauma would have impacted further on the difficulties that he had.

[163] In terms of the MHCAT definition of mental disorder, Mr S has a disorder of mood (arising from his bipolar affective disorder) and a disorder of volition and cognition (arising from his autism interacting with his intellectual disability). This gives rise to a risk to others, which fluctuates over time. He also has a seriously impaired capacity for self-care, which relates to both his autism and intellectual disability.

[164] Dr Barry-Walsh gave evidence about how Mr S's assaultive tendencies are proximately a result of his major difficulties with anxiety. His anxiety is caused by a combination of his autism and intellectual disability. Any change or stress can drive an increase in his level of anxiety leading to outbursts of aggression. His autism can lead to marked inflexibility, proclivity for anxiety, an aggressive response to changes in environment and substantial difficulties in his capacity to read or understand other people. It is these problems with anxiety that means he can rapidly deteriorate into an angry and assaultive state.

[165] This clinical evidence was, in a rather more anodyne sense, confirmed by the interviews with the Mr S himself. When he was asked whether there were times he had hurt the staff at Haumietiketike he replied "yes". He said that he "hurt the staff" because he was "pissed off". He talked about the "old" Mr S who "used to punch everyone" and used to "put people on the ground".

[166] Mr S currently resides in one of the 'step-down' cottages at the Porirua hospital site. Dr Judson gave evidence about the very detailed plans put in place to facilitate the transition to the cottage. Dr Duncan described Mr S's paradox that on the one hand he wanted to move to accommodation that allowed him more freedoms and choice; but how he would become very anxious when that was put in place.

Mr M

[167] 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. Dr Duff said that Mr M's childhood was clearly a very adverse one for him.

[168] 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. He apparently set fire to his own IHC unit. 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.[81]

[169] 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.

[170] He reoffended again with wilful damage and assault in 1995, when he smashed a car with a baseball bat and attempted to hit his care-giver. He was again found to be under disability, and was readmitted to the Mason Clinic, although he returned to the community relatively quickly.

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[81] It is not clear what happened in relation to that charge. The file suggests he was remanded to Mt Eden prison and that an assessment of fitness to plead was undertaken. The psychiatrist who undertook the assessment noted that he was unable to instruct his lawyer and had little understanding of the Court process. But because at that time (which was post MHCAT Act but pre CPMIP Act) Mr M was considered to be intellectually disabled but not mentally disordered no finding of unfitness could be made.

[171] Between 1996 and 2000, Mr M resided in Spectrum Care (an 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.

[172] 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 CJA and on 20 December 2001 was ordered to be detained as a special patient under the MHCAT Act at the Kauri Unit in the Mason Clinic. That status was continued on 10 April 2002, 23 July 2002, and 9 October 2002.

[173] 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. Dr Judson's evidence in this respect 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.

[174] 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.

[175] 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 MHCAT Act (but now pursuant to s 24(2)(a) of the new CPMIP

Act). On 14 October he transferred to the Pūrehurehu Unit. On 18 November 2004 he assaulted District Inspector John Edwards.

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

[177] 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 S 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.

[178] On 6 July 2007 Mr M was transferred pursuant to s 47A of the MHCAT Act from special patient status under that Act to special care recipient status under the IDCCR Act. That status was continued on 12 January 2008, July 2008 and 19 December 2008.

[179] Following the expiry of half the maximum (14 year)[82] sentence for the assault with intent to rob charge on 20 December 2008, on 14 January 2009 the Attorney-General directed that Mr M's status was to be changed under s 31(4) of the CPMIP Act from special care recipient to a secure care recipient.

[180] His status as a care recipient was extended on 29 June 2009 by Judge Adams.[83] His oral judgment records that the hearing had been attended by 14 people, including both a lawyer and support person for Mr M, a member of 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. Parts of Judge Adams' decision (in which he extended the care order for another 12 months) are set out later in this judgment. For present purposes, I note his comments that:

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82 Crimes Act 1961, s 236.

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

> … despite the minimal changes that have been made, there is a rigorous professional hopefulness in the approach expressed through Ms McClintock's submissions for RIDCA and in Dr Duff's report.
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> … It is well known that [Mr M] has been critical of the Pōhutukawa unit, not necessarily a fair assessment on his part, but nonetheless a strongly held subjective one for a period of time. There is a clinical question, I think, as to whether moving a person because they say they want to be moved, is a helpful thing clinically or not because inevitably it involves the loss of those useful relationships and routines and the need to build new ones which takes up some energy. There is always the possibility that the care recipient may find that the change feels like a worse one after they have been in a new situation for a time. I think there is always the possibility that a person who is not eager to engage in activities can, perhaps, use criticism of the place they are in as a means of supporting them in non-engagement.

[181] 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 and his compulsory (secure) care order was further extended by Judge Hikaka for two years on 6 October 2010.

[182] 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.

[183] 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, intentionally, no further extension was sought.

Presentation

[184] Mr M has a low IQ combined with a well-established personality disorder. Dr Duff said that (unlike Mr S and Mr C) his aggression towards others related to his developmental deficits, rather than a lack of a theory of mind flowing from autism spectrum disorder. But although Mr M is the only one of the applicants without autism, Dr Duff said he is 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.

[185] Dr Duff commented about his 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 …

[186] 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 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 …

[187] 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 have not met his needs immediately. Mr M has also, however, 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 ...

Mr C

[188] Mr C was born in Auckland in 1970. He was reportedly expelled from his intermediate school at age 14 for displaying violent behaviour. In September 1984, Mr C was reviewed by a child psychiatrist at Auckland Hospital due to problems with frequent absconding and increasing aggressiveness. It was noted that he had become "uncontrollable" at home and at school and that his "aggressive outbursts seemed to be related to attempts at limit setting or frustration in some other area … and occur[ed] purely spontaneously." Mr C was briefly admitted to Carrington Hospital for four weeks following charges in relation to damage at his grandmother's house.

[189] In August 1991, Mr C was charged with common assault after grabbing a male staff member around the throat and attempting to punch him.[84] Mr C spent two months in the Mason Clinic in 1993, following an assault in August that year. In 1999, there was an escalation in Mr C's aggression and violent behaviour. He made repeated phone calls to staff and others, and some were threatening and abusive. He broke windows at his residence, and assaulted staff members. Mr C also complained of a man "inside his head" talking to him and telling him to hurt people.

[190] On 31 October 2001, Mr C was reportedly left alone after being brought to a workplace in Onehunga by his advocate. He became agitated and assaulted two female staff members of the Parent and Family Resource Centre. He was charged with two charges of Male Assaults Female.[85]

[191] Following further difficulties, Mr C was arrested on 6 December 2001 and remanded in Mt Eden prison. While in prison, his care was transferred to Tīmata Hou, and he was bailed to the community on 24 January 2002. Because his release coincided with a holiday weekend the service struggled to provide for Mr C's complex needs. Following episodes of irritability and physical and verbal abuse towards staff and other patients, Mr C was again arrested. He was charged with intentional damage, and threatening to injure and assault. He was admitted to the Totara Unit at the Mason Clinic.

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84 The final disposition of that charge is unknown.

85 Again, it does not seem to be known what happened in relation to this charge.

[192] In the court proceedings which followed, he was found to be under disability and ordered to be held as patient (not a special patient) pursuant to s 115(2)(a) of the CJA on 15 March 2002. He was transferred to Te Huia in Porirua on 21 August 2002.

[193] Dr Judson spoke about how difficult it was to deal with Mr C at this time:

> … when he came to Te Huia he was very, very unpredictable so that he would erupt with periods of sudden aggression without really any warning and I think it was that unpredictable and actually quite difficult to contain aggressive behaviour which were to do with his anxiety as an autistic man but we had, you know we had a lot of people who were very skilled and experienced in reading and managing people with autistic disorders and you can often see the anxiety beginning to build …. [Mr C] was particularly difficult because … his anxieties and his outbursts would be quite unpredictable often and difficult to spot. Sometimes you'd see it coming up otherwise it wouldn't be and so he took a lot of skilled management and I'm aware even now that, you know that he's quite a challenge and requires a lot of specific resources within the Mason Clinic to manage him.

[194] His status as a patient under the MHCAT Act was continued on 4 July 2002 and 2 September 2002. His compulsory inpatient treatment order was extended on 1 October 2003. His status was reviewed and continued on 11 February 2003.

[195] On 15 March 2003 Mr C's compulsory inpatient treatment order was indefinitely extended. His status as a patient under the MHCAT Act was reviewed and continued on 24 December 2003, 5 July 2004 and 8 December 2004. He was transferred to the Haumietiketike Unit after it opened around August 2004. His status was reviewed and continued on 10 June 2005 and 6 December 2005.

[196] On 17 July 2006, he was transferred to Auckland and was admitted to the Pōhutukawa Unit at the Mason Clinic. He has remained there since that date.

[197] Mr C's status as a patient under the MHCAT Act was reviewed and continued on 17 July 2006, 1 December 2006, 15 June 2007, 7 December 2007, 12 June 2008, 1 July 2009, 12 December 2009, 4 August 2010, 22 December 2010, 8 June 2012, 29 December 2011, 13 June 2012, and 12 December 2012.

Presentation

[198] Dr Duff explained why, although Mr C has a relatively high IQ (ie, a "mild" intellectual disability), he does not have the same level of functioning as Mr M:[86]

> An IQ test gives you a number. It's a collection of different puzzles, quizzes and assessments that are normed against a population mean. But it doesn't really tell you about real-life interaction in the world. So the number doesn't necessarily correspond to the person's competencies or capabilities in a general sense. So although Mr C has – can perform these tests and obtain a higher number his functional ability to live independently is probably more impaired than Mr M's is. […] Mr C … sits on the autism spectrum of disorders and that's an additional impairment to his interactions and ability to use his theoretical knowledge in real-life situations.

[199] Dr Duff said that Mr C's autism was profound and severe. Even though he will sometimes attend group activities, she described him as "walking alongside" others rather than really fully interacting with them. She explained that Mr C's autism also means that his assaultive behaviours are impersonal:

> … Mr C … doesn't have the sense of a person being more important than a chair, they're just two objects that he interacts with in his environment and … it's not necessary to afford one special consideration. So if he hits you or kicks you, in his view that's no worse than if he punches the wall …. The difference will be in how much it hurts him so probably it's worse to punch a wall because it probably hurts him more in terms of the hardness of the wall by comparison to the hardness of a person. And … he can be in a complete rage assaulting you and then half an hour later he's chatting to you normally so it's not a grudge-bearing, it's really not personal. And it's important not to take it personally then as well so, because – and that is part and parcel of the autism, it's a lack of an ability to put yourself in the shoes of the person who's receiving the assault and to perceive then as an assaulted person, that this is not a nice thing to happen to you, so that's core to the lack of feeling of mind and that inability to place yourself in somebody else's shoes and imagine the world from the perspective of another person.

[200] Dr Duff explained that Mr C does not demonstrate pre-planning as Mr M does; rather his violence tends to be "more immediately reactive". She said:

> Mr C, when he's in an aroused state, explosive levels of aggression that can be very sudden or very overwhelming or very aggressive in the moment, very frightening. He's very, very vocal when he becomes aroused and so he will scream and swear and yell and throw things and so everybody in the environment is very acutely conscious of the level of anger he's displaying. He will damage objects and he will assault people fairly randomly, depending

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[86] Mr C's IQ has been assessed at around 61. Mr M's is around 53. Mr S's has been assessed as being somewhere between 54 and 69.

> on who happens to be in his path. It's not personal for Mr C, whereas it's often much more personal, in my experience, for Mr M.

[201] In his interview, Mr C spoke about it being a "long time ago", that he hurt any of the other people living at the Pōhutukawa Unit. But Ms Medlicott's evidence was that he had been involved in an assault on another patient in the Unit just the week before she met with him. Mr C described how he needs to "not lose [his] cool and not get upset on the phone" in order to transition into the community.

Summary: the bases for the applicants' initial and ongoing detention

[202] Each of the applicants became subject to orders detaining them in hospitals as a result of a criminal justice process. Each was found to be "under disability" or "unfit to stand trial" on charges involving moderately serious violence. More particularly:

(a) in relation to Mr S's most recent charge of male assaults female, the Court ordered detention as a special patient under 24(2)(a) of the CPMIP Act on 22 December 2005;

(b) in relation to Mr M's most recent charge of assault with intent to rob, the Court ordered detention as a special patient under s 115(1) of the CJA on 20 December 2001;

(c) in relation to Mr C's most recent two charges of male assaults female, three charges of intentional damage, and charges of assault and threatening with intent to frighten, the Court ordered detention as a patient under s 115(2)(a) of the CJA on 15 March 2002.

[203] The effect of Mr C's order was that he became subject to a six month compulsory inpatient treatment order under the MHCAT Act, and the charges against him were immediately stayed. He was no longer subject to the criminal justice process from that point in time. After the first six months of his treatment as a compulsory inpatient, his responsible clinician made an application to the Family Court for a further six month order. Upon the Court granting a further extension of the compulsory treatment order, it became indefinite. Mr C's status is, nonetheless

reviewed six monthly and he can be discharged at any time, in the event that a clinical review finds that he is fit to be released from compulsory status.

[204] Because Mr S and Mr M were detained as special patients, they initially continued to have live charges against them and were required to remain detained in hospital while they received treatment. Every six months their responsible clinicians were obliged to review their mental impairments and issue a certificate stating their findings. On the expiry of half the maximum sentences for their respective index offences they continued to be regarded as unfit to stand trial. At that point the Attorney-General was required to direct that they be detained as patients (or care recipients).[87] That direction:

(a) was deemed to be a (civil) compulsory treatment (or care) order; and

(b) meant that the criminal charges against them were stayed and they were no longer subject to the criminal justice system.

[205] From that point onwards they had formal clinical reviews every six months and could (as a result) be released from compulsory status, as Mr M in fact was, in 2013. Their continued detention is (or was) authorised by orders made by the Family Court. As I have said, on the second six month extension, orders made under the MHCAT Act are indefinite (but subject to ongoing six monthly clinical reviews). Orders under the IDCCR Act are always time limited but can be renewed indefinitely (subject to ongoing regular clinical reviews).

SECTIONS 9 AND 23(5) OF THE NZBORA

[206] Eleven of the thirteen causes of action in the amended statement of claim allege that ss 9 and/or 23(5) were breached in some way. Almost every aspect of the applicants' detention is challenged in terms of those sections.

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[87] Mr S became subject to a compulsory inpatient orders under the MHCAT Act. Mr M, who had earlier been transferred from special patient status to special care recipient status under the new IDCCR Act, became a compulsory care recipient under the IDCCR Act.

[207] The ubiquity of ss 9 and 25(3) in terms of the applicants' claims, and the differences between the parties as to the ambit of the rights they protect, makes it useful to consider as a preliminary matter the established reach of those provisions. I then also outline the approach which should, in my view, be taken if (on the facts) a breach is seriously in issue.

[208] Section 9 of the NZBORA provides:

> Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment.

[209] And s 23(5) states:

> Everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person.

[210] The applicants' claims suggest that one or both of these sections encompass a range of "rights", including:

(a) a right to autonomy and dignity;

(b) a right to freedom from unlawful discrimination;

(c) a right to receive a proper and impartial investigation of alleged breaches of s 23(5);

(d) a right to rehabilitation;

(e) a right to reasonable "home-like" living conditions, including a "positive therapeutic environment", and adequate food, heating, lighting, space and sanitation;

(f) a right to adequate medical care;

(g) a right to refuse medical care; and

(h) a right to family life and privacy, which includes rights to:

(i) undisturbed sleep;

(ii) receive condoms;

(iii) form and maintain intimate relationships;

(iv) family life and therefore the right to marry, enter a civil union or de facto relationship;

(v) masturbate in private;

(vi) a "sense of security and personal autonomy"; and

(vii) receive care in the least intrusive manner.

[211] The respondents submitted that the majority of the above rights are not guaranteed by NZBORA ss 9 and 23(5) or, indeed, any other provision in that Act. They accepted, however, that some are recognised and protected elsewhere in the law.

The content of the s 9 right

[212] The Supreme Court's decision in *Taunoa v Attorney-General* remains the leading authority on the application and ambit of ss 9 and 23(5).[88] The plurality held that ss 9 and 23(5) establish a hierarchy of proscribed conduct. Thus:

(a) s 9 is "reserved for truly egregious cases",[89] involving official conduct "which is to be utterly condemned as outrageous and unacceptable in any circumstances"; and[90]

(b) by contrast, s 23(5) is breached by State conduct that is less reprehensible, but still unacceptable.[91]

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88 *Taunoa v Attorney-General* [2007] NZSC 70, [2008] 1 NZLR 429.
89 At [297] per Tipping J.
90 At [170] per Blanchard J.
91 At [170] per Blanchard J and [285] per Tipping J.

[213] Conduct breaching s 9 will usually involve an intention to harm or conscious and reckless indifference to the causing of harm, as well as significant physical or mental suffering. The Court encapsulated what kind of behaviour was covered by s 9 is directed as follows:

(a) "torture" involves the deliberate infliction of severe physical or mental suffering for a proscribed purpose, such as the obtaining of information;[92]

(b) "cruel" treatment is treatment which deliberately inflicts suffering or results in severe suffering or distress;[93]

(c) "degrading" treatment is treatment which gravely humiliates and debases the person subjected to it;[94] and

(d) "disproportionately severe" treatment is conduct which is so severe as to shock the national conscience, or so disproportionate as to cause shock and revulsion. It imports conduct which is well beyond treatment that is manifestly excessive.[95]

[214] The Supreme Court identified the following factors as potentially relevant to an assessment of an alleged breach of s 9:[96]

(a) the nature of the conduct being examined;

(b) the state of mind of the party responsible for the conduct; and

(c) the effect of the conduct on its victims.

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92 At [81] per Elias CJ and [171] per Blanchard J.
93 At [171] per Blanchard J and [282]-[283] per Tipping J.
94 At [171] per Blanchard J.
95 At [172] per Blanchard J and [289] per Tipping J.
96 At [291], [294] and [295] per Tipping J, and [353] and [360] per McGrath J.

The content of the s 23(5) right

[215] As the wording of subs (5) makes clear, the right is predicated on the right-holder first having been deprived of his or her liberty.

[216] Many cases invoking s 23(5) concern actions by a detaining authority that are self-evidently inconsistent with the dignity or humanity of the detainee, such as unnecessary use of force or assault. For example, the intentional infliction of injuries by a police officer and inappropriate use of pepper spray against a person in custody have been found to breach s 23(5).[97]

[217] But inaction, neglect or failure to take the necessary steps to ensure the humane treatment of a detainee have also been discussed by the courts, and positive duties recognised under s 23(5). There is no doubt (and the respondents accept) that s 23(5) requires the State not simply to refrain from inhumane conduct, but also to act to maintain minimum conditions of detention, as defined in the statute authorising the detention, subordinate legislation and/or any relevant standards. The extent to which that positive duty might extend still further is one of the matters discussed more fully, below.

Taunoa

[218] *Taunoa* itself concerned a number of failures to meet this positive requirement in relation to a so-called "Behaviour Management Regime" (BMR) that had been implemented at Paremoremo prison. In the High Court, Ronald Young J singled out specific aspects of the BMR which ultimately led him to find that the BMR as a whole breached s 23(5). He held that:[98]

(a) the BMR involved lengthy periods of effective segregation without the protection of the process set out in the (then) Penal Institutions Act 1954 for initiating and ending such periods;

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97 *Falwasser v Attorney-General* [2010] NZAR 445 (HC).

98 *Taunoa v Attorney-General* (2004) 7 HRNZ 379 (HC) at [276].

(b) isolation as the result of an administrative policy becomes a "punishment" when there was a loss or reduction of the prisoners' conditions of detention;

(c) the conditions of detention experienced by prisoners who were subject to the BMR were below those mandated by the Penal Institutions Act and associated regulations, including:

(i) inadequate changes of bedding and clothing, and inadequate cell cleaning;

(ii) inadequate monitoring of mental health at entry or at regular intervals;

(iii) inadequate exercise conditions;

(iv) insufficient natural light;

(v) routine strip searching which lacked privacy and failed to preserve dignity; and

(d) some of the BMR rules which were not found to be plainly unlawful were nonetheless "pointlessly punitive".

[219] The Court of Appeal generally endorsed the High Court's analysis and approach. It said:[99]

> [A] Judge considering s 23(5) must undertake an evaluative exercise having regard to the conditions under which inmates are held, the extent to which these diverge from the conditions which ought to have applied if there had been compliance with legal requirements and, in some circumstances, the extent to which those legal requirements are insufficient to meet the s 23(5) standard.

[220] By the time *Taunoa* reached the Supreme Court, the Crown had conceded the BMR breached s 23(5). Thus that Court's decision is of limited assistance in

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[99] *Attorney-General v Taunoa* [2006] 2 NZLR 457 (CA) at [145].

determining the positive obligations of detaining authorities under s 23(5). Nonetheless the following points emerge from the judgment:

(a) s 23(5) responds to the special vulnerability of prisoners and others deprived of their liberty;[100]

(b) s 23(5) imposes a positive duty of humane treatment on the Crown;[101]

(c) s 23(5) is based on art 10(1) of the ICCPR,[102] and so the United Nations Standard Minimum Rules for the Treatment of Prisoners (also known as the Mandela Rules) which are used by the Human Rights Committee as a tool for assessing art 10 ICCPR compliance, will influence New Zealand decisions on compliance with it;[103]

(d) while the content of the s 23(5) right will be informed by an analysis of comparative jurisprudence, it will ultimately be determined by reference to New Zealand standards and values.[104] A relevant touchstone would be conduct which, while not outrageous or reprehensible, is regarded as unacceptable in contemporary New Zealand society;[105] and

(e) s 23(5) captures "conduct which lacks humanity, but falls short of being cruel; which demeans the person, but not to an extent which is degrading; or which is clearly excessive in the circumstances, but not grossly so".[106]

Other cases in which a breach of s 23(5) has been found

[221] In *Vogel v Attorney-General* the plaintiff was a prisoner who had been sentenced to 21 days of cell confinement by a Visiting Justice for failing to provide

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100 *Taunoa* (SC), above n 88, at [78] per Elias CJ and [177] per Blanchard J.
101 At [78] per Elias CJ, [177] per Blanchard J, and [294] per Tipping J.
102 At [28]-[31] and [78] per Elias CJ, and [162]-[163] per Blanchard J.
103 At [28]-[31] per Elias CJ and [180] per Blanchard J.
104 At [11] per Elias CJ, [179] and [213] per Blanchard J, and [279] and [292] per Tipping J.
105 At [11] per Elias CJ and [170] per Blanchard J.
106 At [177] per Blanchard J.

urine samples.[107] Mr Vogel had requested a detention period of that length in order to assist him to break a drug addiction. But the sentence was greater than that permitted by the relevant disciplinary regulations in force at the time.

[222] Relying on *Taunoa*, the Court of Appeal held that the positive duties towards prisoners under s 23(5) could be breached by a simple failure to meet a statutory obligation, despite the absence of intent on the part of the detaining authorities. The Court held that the maximum period of cell confinement was an important protection for the mental health and well-being of prisoners and that the fact that Mr Vogel had sought a longer period was insufficient to excuse a breach of the positive duty owed to him. Because he was a vulnerable person, his preferences could not be a relevant consideration in determining whether s 23(5) obligations had been met. The Court accordingly found that the unlawful sentence of cell confinement was a breach of s 23(5), because Mr Vogel had not been treated with humanity and respect for his inherent dignity.

[223] In *Reekie v Attorney-General*, the plaintiff (who was a prisoner whose claims related, inter alia, to his treatment in the Auckland Prison High Care Unit) had been mechanically restrained on a 'tie-down' bed for periods of time.[108] While certain forms of restraint were permitted on the tie-down bed, the use of ankle straps breached the relevant regulations, and was found by the High Court to be demeaning and in breach of s 23(5). As well, Mr Reekie was held in a cell that did not meet the minimum requirements and was denied the minimum allowance of recreation time on multiple occasions, which was also found not to be "humane treatment consistent with human dignity". Routine strip-searching was also found to breach s 23(5).

[224] And in *Attorney-General v Udompun* an inadvertent failure of authorities to provide appropriate sanitary products to a menstruating immigration detainee was found to constitute a breach of s 23(5).[109]

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107 *Vogel v Attorney-General* [2013] NZCA 545, [2014] NZAR 67.
108 *Reekie v Attorney-General* [2012] NZHC 1867.
109 *Attorney-General v Udompun* [2005] 3 NZLR 204 (CA).

Cases in which a breach of s 23(5) has been asserted but not established

[225] There are numerous decisions in which breaches of s 23(5) have been alleged but not proved. Those cases include, most notably, the decisions in *B v Waitemata District Health Board* which are the most comprehensive and authoritative considerations of s 23(5) in a hospital context.[110] That case concerned the legality of a policy adopted by the WDHB to prohibit smoking on its property. This meant that compulsorily detained patients could not smoke at all, unless granted leave to go outside the grounds.

[226] In upholding the High Court's conclusion that s 23(5) was not breached, the Court of Appeal found that, given that s 23(5) was only triggered when the right-holder was detained, an expansive view of the right based on concepts of "liberty" or "autonomy" was inapt. Rather, it "must be read as a whole and expresses one important idea: treating persons with humanity embraces respect for their dignity".[111] There are necessary and inevitable limitations on detainees' freedoms.

[227] In terms of whether the s 23(5) right required that those detained in a mental health context be permitted to smoke, the Court said that although restrictions on smoking are not necessary limitations on detainees' freedoms, smoking is not central to the humanity of the affected detainees. Rather, smoking was a lifestyle choice and not central to a person's identity or development as a human being.[112] The requirements of good medical practice were "an apt starting point" when considering whether the impugned smoke-free policy breached s 23(5).[113] And here, the provision of smoking cessation support for patients who were experiencing withdrawal was held sufficient to meet the treatment with humanity standard.

[228] In upholding the decisions in the Courts below, the Supreme Court:

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110 *B v Waitemata District Health Board* [2013] NZHC 1702, (2013) 29 FRNZ 186.
111 *B v Waitemata District Health Board* [2016] NZCA 184, [2016] 3 NZLR 569 at [74].
112 At [77]–[79].
113 At [33].

(a) agreed with the Court of Appeal's rejection of the appellant's submission that "humanity" and the "inherent dignity of the person" are two separate limbs;[114] and

(b) rejected the submission (based on dicta in *Udompun*) that personal autonomy is "a component of dignity or at least part of s 23(5) in its entirety",[115] confirming the Court of Appeal's view that:[116]

> s 23(5) does not confer "an unbounded freedom" of those who are detained "to do as they please".

[229] The Court said that, on the facts, the appropriate s 23(5) focus was not the policy itself but whether the methods adopted by the DHB to help patients to stop smoking were themselves humane and consistent with dignity.[117]

[230] Next, there is *Toia v Prison Manager, Auckland Prison*, a case in which the Courts found breaches of the legislation regulating the conditions of detention but no breach of s 23(5). [118]

[231] Mr Toia was a prisoner who made multiple complaints about his detention in maximum security and the At-Risk Unit (ARU) at Auckland Prison. The High Court found that although Mr Toia's transfer to ARU was for legitimate purposes, it amounted to de facto segregation without the protections afforded by the Corrections Act 2004 and therefore breached that Act.[119] The Court of Appeal upheld the High Court's findings that, in spite of the breach of the 2004 Act, there was no breach of s 23(5) because:[120]

(a) moving Mr Toia to the ARU was not of itself unlawful;

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114 *B v Waitemata District Health Board* [2017] NZSC 88, [2017] 1 NZLR 823 at [57].
115 At [61].
116 At [61] quoting *B* (CA), above n 111, at [77].
117 At [62].
118 *Toia v Prison Manager, Auckland Prison* [2014] NZHC 867; *Toia v Prison Manager, Auckland Prison* [2015] NZCA 624.
119 *Toia* (HC) at [63]-[67].
120 *Toia* (CA) at [30].

(b) the prison authorities were having to respond to a physically strong and aggressive prisoner who was obstructing them in the execution of core duties;

(c) Mr Toia's prisoner management plan had remained operative;

(d) although his ability to associate with other prisoners was removed, it was not intended the transfer would be of long duration and, in fact, it was not;

(e) while the sanitation standards were minimal:

(i) they were adequate on a temporary basis;

(ii) Mr Toia's own conduct had contributed to them; and

(f) Mr Toia did not suffer any harm as a result of being subjected to the ARU regime.

[232] Similarly, although the absence of a privacy screen in the maximum security cells at Auckland Prison was also a breach of the Corrections Regulations,[121] it was found that Mr Toia had been accorded the degree of privacy necessary while detained in a maximum security cell. Brewer J in the High Court found that while privacy is an aspect of humane treatment under s 23(5), it is not absolute and there had been no breach of that section.[122] A breach of the prison complaints system was described as "technical" only, and also did not breach s 23(5).[123]

[233] Other conduct by a detaining authority held not to breach s 23(5) includes:

(a) requiring a prisoner to wear a prison-issued jumpsuit during family visitation;[124]

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121 *Toia* (HC) at [100].
122 At [101]-[102].
123 At [145]-[147].
124 *Forrest v Chief Executive of the Department of Corrections* [2014] NZHC 1780.

(b) requiring a man arrested for drink-driving to stand near to a police car containing two female officers while urinating;[125]

(c) holding a detained person's jaw to prevent him spitting on the constable concerned;[126] and

(d) the use of reasonable force to prevent a detained person swallowing drugs and to induce him to spit the drugs out.[127]

Positive duties under s 23(5)

[234] As I have said, it is not disputed that s 23(5) incorporates a positive duty on detaining authorities to meet any specified minimum conditions of detention as set out (for example) in the Mandela Rules (in the case of prisoners). There is, however, a question about how much further such positive duties might extend.

[235] The respondents suggested that a common law duty of care may also inform the content of s 23(5). Historically, and in cognate jurisdictions, such a duty has been held to follow from the particular vulnerability of those in custody and the assumption of control by the detaining authority.[128] Many of those who are detained will have a limited ability (either as a result of their detention or as a result of the circumstances which led to it or both) to protect themselves. Such a duty has been held to require that, in certain circumstances, the detaining authorities should act in a positive way to keep a detainee safe. The steps required by such a duty not only go further than mere compliance with the applicable minimum standards of detention but further than requiring the adequate supervision of inmates to prevent their coming to harm. It includes the avoidance of all acts or omissions which the person having custody could "reasonably foresee would be likely to harm the person for whom he is responsible", including self-harm.[129]

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125 *Paniora v Police* [2014] NZHC 3363.

126 *Young v Attorney-General* HC Auckland CIV-2002-404-1981, 23 December 2008

127 *R v Roulston* [1998] 2 NZLR 468 (CA).

128 See for example *Ellis v Home Office* [1953] 2 All ER 149 (QB).

129 *Kirkham v Chief Constable of Greater Manchester* [1990] 2 QB 283 at 294. The existence of such a duty, and any bearing it might have on the content of s 23(5), is relevant in the present case particularly in the context of the allegations made by Mr S that he was sexually abused by another patient in late 1999 and early 2000. Although his negligence claim relating to those events was abandoned, there remains an issue about whether, in not taking steps to prevent this from

[236] A common law duty of this kind may be regarded as established in the United Kingdom. It has also found acceptance in Australia,[130] and in pre-ACC New Zealand, albeit in limited circumstances.[131] More recently, Allan J in this Court held that it was unsafe to strike out a claim based on an alleged breach of such a duty because of the limited oral argument he had heard on the point.[132] In doing so he said:

> [64] It is clear that there are cases in which the superintendent or manager of a prison may owe a duty of care to a prisoner at common law. The cases suggest that the circumstances in which a duty of care may be established are relatively limited. For example, in *Morgan v Attorney-General* Tompkins J found that a duty existed to exercise reasonable care for the safety of prisoners, and that a workplace injury suffered by the prisoner whilst in custody was actionable.
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> [65] Likewise, in *Reeves v Commissioner of Police* the House of Lords noted that the Commissioner accepted that he owed a duty of care to the deceased who committed suicide whilst in police custody. [133] A case which is even closer to the present facts if (sic) *R v Deputy Governor of Parkhurst Prison ex parte Hague*, where there were allegations of prisoner mistreatment. In one of the two appeals, the plaintiff had been lawfully detained pursuant to a sentence of imprisonment, but claimed damages for false imprisonment on the basis that prison officers had, without good cause, dragged him from his cell, kept him without clothes in a strip cell and assaulted him. Lord Bridge of Harwich considered that a duty of care to a prisoner might arise in certain extreme cases:
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> > Whenever one person is lawfully in the custody of another, the custodian owes a duty of care to the detainee. If the custodian negligently allows, or a fortiori, if he deliberately causes, the detainee to suffer in any way in his health he will be in breach of that duty. But short of anything that could properly be described as a physical injury or an impairment of health, if a person lawfully detained is kept in conditions which cause him for the time being physical pain or a degree of discomfort which can properly be described as intolerable,

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occurring, there was a breach of his s 23(5) right.

130 In Australia a similar duty was recognised in *Howard v Jarvis* [1958] HCA 19, (1958) 98 CLR 177. There, the High Court said, in respect of a police officer's duties toward his prisoner generally, that in "assuming control for the time being of his person ... it necessarily followed, in our opinion, that he came under a duty to exercise reasonable care for the safety of his prisoner during the detention" (at 183).

131 *Morgan v Attorney-General* [1965] NZLR 134 at 137; *Pallister v Waikato Hospital Board* [1975] 2 NZLR 725 (CA) at 736. I return to these below.

132 *Taylor v Attorney-General* HC Auckland CIV-2010-404-6985, 11 November 2011, at [67].

133 In *Reeves v Commissioner of the Police* [2000] 1 AC 360 (HL) the police were found to have negligently contributed to his death by their failure appropriately to monitor and house the deceased, in leaving open an observation hatch that was used as a ligature attachment. A 'voluntary' act of suicide in custody could not be considered the sole cause of death while the detaining authority was under a duty to take reasonable steps to prevent suicide – such an act did not negate the duty.

> I believe that could and should be treated as a breach of the custodian's duty of care for which the law should award damages.

(footnotes omitted.)

[237] In the *Morgan* decision referred to here, prison instructions had required the issuing of a certain standard of boots for particular outside work. Mr Morgan was issued inadequate boots contrary to those instructions, and as a consequence he slipped and injured himself with an axe. The existence of internal standards for prisoner safety were an important indication of the appropriate steps for prison staff to take in discharging their duty of care:[134]

> While the issue of smooth-soled boots instead of boots with nails may seem to be a precaution trifling in itself, I think the circumstances here show that it was a precaution regarding which the prison authorities themselves thought it necessary to have a special instruction, so I do not think it can be considered to be trifling here. I do not think it is applying too high a standard of care for a jury to hold that the prison authorities should have carried out that instruction.

[238] A similar duty of care has also been recognised towards compulsory detainees in hospitals. For example in *Reid v Greater Glasgow Health Board* a duty was found owed to compulsory patients to prevent them from jumping out a window and injuring themselves.[135] And in New Zealand, the Court of Appeal recognised the duty of care towards compulsorily detained mental health patients in *Pallister v Waikato Hospital Board*.[136] The Court found that the Board "was under a duty to use reasonable care to protect Mr Pallister against his own suicidal tendencies" (as in *Reid*, Mr Pallister had jumped out a hospital window).

[239] As Mr La Hood submitted, the respondents' acceptance that s 23(5) incorporates a duty to take reasonable steps to keep those in detention safe is further supported by recent amendments to the Crimes Act 1961 in relation to vulnerable adults. A vulnerable adult is defined as:[137]

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134 *Morgan*, above n 131, at 142.
135 *Reid v Greater Glasgow Health Board* [1976] SLT (Notes) 33 (Outer House).
136 *Pallister v Waikato Hospital Board* [1975] 2 NZLR 725 (CA) at 736 per Richmond J.
137 Section 2.

> … a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person

[240] As well as s 151, which imposes a duty on all those with the actual care or charge of such persons to provide them with necessaries and to protect them from injury[138], s 195A creates a crime of failure to protect a child or "vulnerable adult" in the following terms:

> (1) Every one is liable to imprisonment for a term not exceeding 10 years who, being a person described in subsection (2), has frequent contact with a child or vulnerable adult (the victim) and—
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> (a) knows that the victim is at risk of death, grievous bodily harm, or sexual assault as the result of—
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> (i) an unlawful act by another person; or
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> (ii) an omission by another person to discharge or perform a legal duty if, in the circumstances, that omission is a major departure from the standard of care expected of a reasonable person to whom that legal duty applies; and
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> (b) fails to take reasonable steps to protect the victim from that risk.
>
> (2) The persons are—
>
> (a) a member of the same household as the victim; or (b) a person who is a staff member of any hospital, institution, or residence where the victim resides.
>
> …

[241] In light of the common law duty owed to those in detention and Parliament's recent recognition of the particular vulnerability of such persons, I agree that it is appropriate to proceed on the basis that s 23(5) does impose a positive protective duty on those such as the respondents.

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[138] Section 150A makes it clear that in order for a breach of that duty to be criminally culpable, there must be a major departure from the standard of care expected of a reasonable person in the position of the person to whom the duty applies.

The standard of care

[242] If it is accepted that s 23(5) can import positive duties there is a related question about to what standard any alleged breach of such duties must be established. I have already noted that where the duty breached relates to the non-observance of a specific standard or rule relating to minimum conditions of detention then the fact of that breach will be highly relevant to, but not determinative of, a breach of s 23(5).[139]

[243] But there is no such starting point or threshold, in terms of the standard of care to be applied in relation to some wider duty s 23(5) to keep detainees safe. And while there are good public policy reasons which favour requiring detaining authorities to take reasonable positive steps to protect detainees under that subsection, that does not mean that the simple fact that a detainee has come to harm constitutes a prima facie breach of s 23(5). It is necessary, I think, to recognise that it is not possible to predict every instance of harm, and there is no public policy that requires authorities to be sanctioned in cases where appreciated risks were reasonably addressed or unappreciated risks resulted in harm.

[244] As well, the s 23(5) threshold is strongly worded. It prohibits treatment that is without humanity or respect for the inherent dignity of the detained person. As the Supreme Court in *Taunoa* noted, those concepts are to be measured by reference to what is regarded as unacceptable in New Zealand society. So just as a breach of s 23(5) involving positive acts or conduct requires those acts or conduct to be "clearly" (but not grossly) excessive, it might also be thought that a breach involving a failure to act or to protect would require that failure to act to be a clear (but not gross) departure from what might reasonably be expected in the particular circumstances. While I would not be inclined to say that the departure needs to be "major" (as it must in order to found criminal liability) it seems to me that in order to find a breach of any positive protective duty owed under s 23(5) there needs to be a clearer or more serious departure than is required to find a simple breach of the common law protective duty of care.

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[139] *Taunoa, Vogel* and *Reekie* (in terms of s 23(5)) and *Morgan* and *Ellis* (in terms of the common law duty) are as one in holding that a failure to comply with a direction or rule intended to preserve the safety of prisoners is a strong indication that a duty towards those prisoners has been breached.

Conclusions

[245] The discussion above appears to me to support the following propositions:

(a) the starting point is that the bearer of the s 23(5) right is, in fact, detained. Detainees are subject to necessary and inherent limitations on their freedom. Ordinary notions of autonomy or choice are necessarily limited by that reality;

(b) the requirement that detainees must be treated with humanity embraces respect for their inherent dignity;

(c) the question of whether a policy, practice or act breaches s 23(5) is best addressed by examining whether:

(i) the policy, practice or act is a necessary aspect of detention (eg, without which the detention cannot be safely maintained, or the detaining authority's duties cannot be met); and

(ii) a critical aspect of the detainees' humanity and inherent dignity is affected by it;

(d) legislative schemes, standards, policies and practices are helpful in determining the boundaries of s 23(5) in any particular case, because they reflect Parliament's view as to a humane standard of treatment for particular groups of detainees;

(e) a breach of such standards will be indicative, but not determinative, of a breach of s 23(5). There is an additional requirement that the relevant act or omission is "unacceptable" as well as unlawful. There is a severity threshold that must be met in order to establish a breach of s 23(5). Purely technical breaches will not suffice;

(f) s 23(5) generally incorporates common minimum standards of positive treatment for all detainees, including obligation to meet basic human needs, such as nutrition, warmth, clothing and housing;

(g) in addition, the statutory scheme authorising the relevant detention may give rise to further positive obligations on the detaining authority;

(h) s 23(5) also incorporates an obligation on a detaining authority to protect and keep detainees safe from harm. But absent any actual illegality, there must be an unacceptable and serious departure from the standard of care expected of a reasonable person in the position of the detaining authority in order to find that such a duty has been breached; and

(i) the totality of conduct may amount to breach even where each individual impugned act or omission might not be unacceptable by itself.

[246] If the impugned treatment was plainly a function of the detainee's detention, it may nonetheless be inhumane, by virtue of:

(a) its duration or severity (for example the use of more force than was necessary in the circumstances);

(b) any particular vulnerability of the detainee; and

(c) the nature and extent of the actual impact on the detainee.

[247] If the impugned treatment was not obviously connected with the purposes of a detainee's detention, similar questions as to its inhumanity will arise. But if inhumanity is established, treatment which is not a function of the detainee's detention will be more likely to be found in breach of s 23(5) due to the absence of any countervailing state interest in maintaining safe and purposeful detention.

[248] So now, I turn now to consider the causes of action themselves.

FIRST, THIRD AND THIRTEENTH CAUSES OF ACTION – SEXUAL VIOLATION OF MR S

[249] Central to the first, third and thirteenth causes of action is Mr S's claim that he was sexually violated by another CCDHB patient, "JC", on three occasions in 1999 and 2000. The alleged violation involved Mr S being forced to perform oral sex on JC and JC performing oral sex on Mr S.

[250] In October 1999 Mr S and JC had both been transferred from Stanford House in Whanganui to Pūrehurehu. Mr S was 21 and JC was 44. JC had been a special patient since 1983 and had a history of sexual predation. They were allocated bedrooms next to each other, both opening out onto the same shared space). On 22 December 1999, JC was transferred to Te Huia. Two incidents were said to have occurred prior to JC's transfer, one in the dining room at Pūrehurehu and one in JC's room. The third incident was said also to have occurred in the dining room, when JC visited Pūrehurehu to play volleyball.

[251] Mr S's claims in relation to these events are that:

(a) the DHB failed to:

(i) provide a safe place of detention;

(ii) provide "preventative therapy and education" or condoms;

(iii) conduct a prompt and impartial inquiry into the alleged violation;

(iv) provide him with legal advice; or

(v) facilitate a police complaint or ACC claim; and

(b) the investigation by the District Inspector (the fifth respondent) was not conducted properly or impartially.

[252] The specific relief sought under the three causes of action is:

(a) a declaration that the sexual violation and the failure to provide a safe environment was a breach of Mr S's rights under ss 9 and 23(5) of the NZBORA;

(b) a declaration that the investigative process (and the failure to advise Mr S of his rights) was a breach of Mr S's rights under ss 9 and 23(5) of the NZBORA, "read together with the Convention Against Torture Articles 11, 12, 13 and 16";

(c) an order requiring the second respondent to refer to sexual violation files to the Police for investigation;

(d) an order requiring the second respondent to provide appropriate post-trauma treatment;

(e) an order requiring that DHBs and District Inspectors be trained "as to the provisions of the Convention Against Torture";

(f) compensation of $50,000; and

(g) costs.

Narrative of relevant events

[253] As noted earlier, the nature and extent of Mr S's disabilities are such that he was not asked or able to give the Court any kind of detailed account of the events underlying these three causes of action. Accordingly the relevant evidence primarily comprised the documentary record and the evidence given by clinicians and staff who were involved with Mr S at that time. Mr Burgering, was also questioned about his involvement (or lack thereof). Expert evidence about aspects of what happened and the DHB's response to it was given by Dr Webb and Ms Medlicott.

[254] The full factual narrative of Mr S's disclosure and the subsequent investigation was given in evidence by Mr Fairley, who was the Regional Clinical Director of Forensic Mental Health services at the time. Dr Judson (who was then Mr S's

responsible clinician) also addressed the relevant events, although he was away on leave when they occurred.

[255] By way of summary, Mr S first disclosed the abuse on 10 July 2000 to his key-worker, Kirsty Wilson-Spencer. Contact was made with Shelley Gabrielle, Mr S's social worker who met with Mr S that day, and documented their meeting in a file note. That file note records that Mr S said "I want to get the Police involved". It also records that Mr S "talked about how hard it was to talk and to let us know what had been on his mind all this time". Further, Ms Gabrielle noted:

> …he said he felt very relieved. He certainly did not appear distressed at the end of the interview. At times throughout the interview he was upset about how hard he was finding it, but once he had spoken to me he felt much better and was certainly in a good frame of mind.

[256] Ms Gabrielle then reported the matter to Joy Collins, Nigel Fairley, John Crawshaw and Elliot Bell. Dr Crawshaw (who was JC's responsible clinician) subsequently recorded his instructions that staff should be supportive of Mr S but not discuss the allegations with him. The reason given for this was that Mr Fairley was to discuss next steps with the Police and it was regarded as important that staff not contaminate any of Mr S's recollections until the Police had made a decision. He also instructed that no contact was to occur between Mr S and JC.

[257] The following day, Mr S's psychologist, Mr Bell, recorded that Mr S had identified feelings of anxiety around the legal process. Mr S was also told that he was to meet with the District Inspector about the allegations on the coming Friday.

[258] When Mr Fairley briefed the District Inspector about Mr S's allegations he said that Mr S did not appear to want to complain to the Police or otherwise participate in a criminal prosecution, but instead wanted an investigation conducted by a District Inspector. This was based on what Mr Fairley had been told by other staff members involved.

[259] Prior to his meeting with the District Inspector Mr S asked that a staff member, Chris Li, write out a statement for him. In that statement it was recorded that Mr S had reported what had happened because he wanted to relieve the burden from his

shoulders before he moved to the IHC service and because he wanted the alleged perpetrator to go to court and learn not to do the same to other people. He also said that he had not asked for help from staff at the time of the offending because he had been threatened by JC and also because he had not yet established trust with Pūrehurehu staff following his transfer from Stanford House.

[260] There are two documentary records of the 14 July meeting between Mr S and the District Inspector.

[261] The first is contained in the District Inspector's subsequent report. In it, he said that he had outlined to Mr S the available avenues of complaint open to him and that he, Mr S and Mr Li had discussed the options (i.e. an investigation by the District Inspector or a complaint to the Police) for about 15 to 20 minutes. The District Inspector said that he advised Mr S that if he chose the District Inspector route, that might make any subsequent Police investigation more difficult, because the earlier investigation might contaminate the Police evidential process.

[262] The District Inspector recorded that he had left matters on the basis that Mr Li would brief Mr S's other key workers so they could assist Mr S to make a decision about which process he wished to follow.

[263] The District Inspector's account is confirmed by an entry in the progress notes made on the day of the meeting by Mr Li. Mr Li noted that the District Inspector had explained to Mr S that he needed to decide whether to go through the formal justice system (complaint to Police followed by possible court proceeding) or to opt for the District Inspector process, involving an investigation of the allegations and making recommendations for the future. Mr Li noted that it had been explained to Mr S that if he wanted the District Inspector to investigate and if the District Inspector found that the allegations were true, JC would not be punished by way of the criminal justice system. Mr Li also noted that Mr S was to be given a few days to make his decision.

[264] Later the same day, Mr S was seen by Elliot Bell again. Mr Bell noted that Mr S presented well and was very pleased with his meeting with the District Inspector.

[265] The documents record that over the next few days Mr S spoke to staff about the allegations and that in doing so was placing quite heavy demands on their time. It seems that these conversations, and the various views expressed about the decision he should make, made him quite confused. But by 17 July 2000, Mr S had decided to have the District Inspector carry out the investigation. Ms Wilson-Spencer advised the District Inspector accordingly. A meeting between the District Inspector, Mr S and Ms Wilson-Spencer was arranged for 18 July 2000.

[266] The District Inspector records this meeting and his subsequent investigatory steps in his report to Dr Judson dated 24 August 2000.

[267] In terms of the management of the risk posed by JC he noted that:

> Dr Crawshaw, [JC's] Responsible Clinician, and Tim Moss, Registered Psychiatric Nurse, each made the observation that while they and their colleagues were very mindful of the clear warnings concerning [JC's] predatory behaviours when they assumed responsibility for his care, they found a paucity of information in the file materials describing specific incidents or patterns of behaviour. They described how [JC] had been closely monitored when he initially arrived at Purehurehu and how there was some relaxing of the boundaries of such monitoring after several months, which were apparently incident free.

[268] The District Inspector went on to find that, on the balance of probabilities, Mr S had been forced to have oral sex with JC on at least three occasions. He based this finding on:

(a) his view about the respective credibility of Mr S and JC (who had denied to him that the incidents took place);

(b) his review of the material on their respective files which, in broad terms indicated that:

(i) Mr S was the most vulnerable patient at Pūrehurehu;

(ii) JC was a "sexual predator" (who had in fact acted in a similar way towards another patient subsequently); and

(c) his inspection of the places where the events were said by Mr S to have occurred.

[269] As far as this last point is concerned, JC had said during his interview with the District Inspector that the incidents could not have happened because the places where Mr S said they had occurred were in view of staff and other patients. Similarly, Pūrehurehu staff were "quite astonished" at the idea that the events could have occurred as recounted by Mr S without observation. But the District Inspector said:

> The first and third incidents were alleged to have taken place in the dining room at Purehurehu. At first observation, this appears an unlikely venue for sexual contact without observation, given that there are sight lines into the dining room from all four sides. If anyone is in the kitchen, they can see through into most parts of the dining room. There is extended window observation on the side that abuts the central corridor into Purehurehu. There are double-doors which open on the side that is adjacent to the common room, and there are windows on the fourth side out into the courtyard. What the two incidents have in common is that each is alleged to have taken place in an evening, at a time when no-one was in the kitchen, when there were very few or no staff movements along the corridor, in parts of the room not visible from the common room, the first incident when there as no-one in the courtyard, and the third incident at a time when anyone in the courtyard would have been preoccupied by a game of volleyball.
>
> The dining room is a possible venue for such incidents, given the description of them by [Mr S] as essentially opportunistic and of very short duration.
>
> The second incident was alleged to have taken place in the dormitory part of Purehurehu, and I inspected that part of the unit on 31 July 2000 with the assistance of Kirstie Wilson-Spencer, [Mr S's] key worker. There are three separate dormitories in the "open" part of Purehurehu and that staff base has large windows which provide visual monitoring of two of them. Ms Wilson-Spencer showed me the rooms where [JC] and [Mr S] were accommodated. There are four patient rooms in this dormitory, and the staff base looks into a shared lounge or common room that all four patient rooms open onto. Two patient rooms open from each of two sides of the common room, which is approximately square. The shower, which is a shared facility (each room has its own toilet) opens from a third side of the common room, and I noted that when the shower door is open, there is quite a large part of the common room which cannot be seen from the staff base. Excluded from view is the doorway into what was [JC's] room. Shower time in the evening, when the incident is alleged to have taken place, is approximately of a half hour duration, and during this time the shower door would be open between each patient's use of i.e. for variable lengths of time of potentially some minutes duration. There would be quite a lot of coming and going of patients and staff. It appeared to me that it would be quite easy for one patient to move into another patient's room, but particularly the room then being used by [JC], and both to be unnoticed for quite some time.

[270] The District Inspector concluded that while JC was personally responsible for the abuse, the staff managing the care both of JC and Mr S, also bore a "significant responsibility" for not preventing JC's behaviour. He did not, however, elaborate in any way on that finding.

[271] The District Inspector observed that Mr S was not well placed at the Pūrehurehu Unit, a view shared by his clinicians both at the time and at the hearing before me. The District Inspector said:

> I also accept the view of Joy Collins that a person with Mr [S]'s presentation is not properly placed in Purehurehu. She and Tim Moss expressed the view that people with a significant intellectual disability such as Mr S, or with neurological deficit following head injury, are vulnerable in relation to the primary or dominant patient group within Purehurehu, and she expressed the view that over the past three years or so, there appeared to have been more such inappropriately placed patients in Purehurehu, possibly as a result of other places for such people constricting.

[272] The Inspector also noted the advice he had received that Mr S did not appear particularly traumatised. For example, Mr Bell's contemporaneous psychological report, dated 28 August 2000, had noted that:

> [Mr S] appears to have coped well, taking a consistent line throughout the subsequent investigation process and reporting little experience of distress. Some residual work on safety strategies for [Mr S] has been undertaken with a view to preventing his potential for re-victimisation.

[273] Ultimately, the District Inspector made four recommendations:

> I recommend that those treating [Mr S] take available opportunities to reinforce to him that he can trust staff if he is uncomfortable with any co-patient's behaviour. I also recommend that different placement options for him be actively explored, and I am pleased to be advised that such exploration is already well under way. If any adverse impact from these events on him is detected by those caring for him, then I recommend that a specific therapeutic programme be devised for him.
>
> In relation to [JC], I recommend that the treatment modalities, containment, psychotherapy and/or medication continue to be explored, with it being clearly noted that containment must remain at a high level until there has been substantial progress on a different treatment approach. Concerning medication possibilities, if andracur is considered to be an optimal treatment, I recommend that careful consideration is given as to whether it properly comes within the statutory ambit of "treatment for mental disorder" and, if it is accepted that it does so for [JC], that his Responsible Clinician obtains a second opinion pursuant to Section 59(2)(b), perhaps asking the Review

> Tribunal to appoint a clinician whom the Tribunal believes would be particularly well-equipped to consider the issue.
>
> I recommend that there should be a very clear identification on [JC's] file now of his having a problem of being a sexual predator and of his modus operandi, at least in relation to Mr [S] and the other patient referred to. A clear description of these recent incidents should alert those responsible for his care in future to the types of situation or type of people who may be at risk.
>
> Staff at Purehurehu and Te Huia should also collectively receive some training input regarding managing predatory/vulnerability risks between patients, including but not limited to sexual predation.

[274] His concluding comment was that:

> Joy Collins made the observation to me that there is little guidance available to her or her colleagues as to how to address or manage the sexual needs of patients, particularly those in long term care. I suggest that any known protocol or recommended practice on this issue be made available to her, and managers of other longer term units. If there is no such protocol or practice, and I am not aware of one myself, I recommend that this issue be raised with the Director of Mental Health for the purpose of clarification of policy at a national level.

[275] The view expressed by Mr Bell at the time about the effect of the abuse on Mr S was endorsed at the hearing before me. For example Dr Judson confirmed that although a close eye was kept on him to see whether he had been traumatised:

> … he didn't seem to be displaying anything that suggested that he was particularly traumatised by the behaviour. He was frightened about the perpetrator but he was particularly anxious to make sure that his allegations were believed and taken seriously and I think that was probably the most reassuring thing for him that it was dealt with in that way.

[276] Dr Duncan's evidence was that the support Mr S received from Mr Bell at this time was the sort that he would have expected for someone in Mr S's position.

The claims

Failure by the DHB to provide a safe place of detention

[277] At the outset I record that I proceed on the basis of the District Inspector's conclusion (on the balance of probabilities) that the alleged sexual violation did occur. There is no basis upon which I can or should go behind that now, over 15 years later.

[278] I also accept at the start the respondents' submission that, in the absence of the detaining authority's knowledge of (or at least reckless indifference to) a serious and immediate risk, sexual violation by a co-detainee could not constitute a breach s 9 of the NZBORA. As discussed above, the bar set by the Supreme Court in *Taunoa* is a high one. And notwithstanding the District Inspector's view that the CCDHB bore "significant responsibility" for what occurred, there is no indication in his report that he considered that the staff knew of or were recklessly indifferent to such a risk. As noted earlier, staff expressed amazement that any opportunity could have arisen where JC could do as he did without observation. In that context it is also relevant to note the finding that the events were "essentially opportunistic and of very short duration."

[279] However, based on their acceptance that the section incorporates a positive duty to protect detainees from (reasonably foreseeable) harm, the respondents acknowledged that a breach of s 23(5) was at least arguable here. There can be little doubt that failing to protect a particularly vulnerable detainee from sexual assault by another detainee is capable of engaging notions of humanity and dignity.

[280] But there is immediately a problem. While the CCDHB accepts that the assaults should not have happened, it does not accept the District Inspector's "significant responsibility" finding, for which no specific reasons were given. There is necessarily great difficulty in now determining whether there were any culpable failings on the DHB's part or whether there were reasonable protective steps that could have been taken but which were not.

[281] More particularly, there is some force in the respondents' point that the District Inspector's report contains somewhat confusing findings about the extent of the information available to JC's clinicians at the time about the risk that he posed, either generally or to Mr S in particular. On the one hand, the District Inspector noted that there was "very clear" file information regarding JC's "sexually predatory behaviours of a homosexual orientation" recorded by staff at Stanford House. But he also reports that although JC's clinicians were mindful of these warnings, the files did not record specific incidents or behaviour. It seems that this had resulted in JC being closely monitored for several months after his transfer, but that the monitoring was subsequently relaxed somewhat after an apparent absence of adverse incidents.

[282] The difficulty arising from the absence of further information is compounded by the fact that the applicants did not put any specific alleged failings to any of the many witnesses with clinical responsibility for Mr S at the time, or called any witness with clinical responsibility for JC. Rather, the submission seems simply to be that the assaults speak for themselves and "should not have happened". While that is of course true (and is consistent with the District Inspector's own conclusions), without further evidence about the precise circumstances which gave rise to the assaults or some suggestion being put of how things might reasonably have been done differently or better (both of which is made difficult due to the effluxion of time) it would be unfair to find that a breach of rights occurred.

[283] The most that can really be said is that:

(a) the CCDHB was clearly aware of Mr S's particular vulnerability as a young, intellectually disabled, patient at Pūrehurehu;

(b) the CCDHB was also aware of JC's history and that he had been assessed as posing a high (sexual) risk to others;

(c) despite intense monitoring of JC upon his arrival at Pūrehurehu, oversight was relaxed somewhat following an absence of reported incidents;

(d) from late December 1999 JC and Mr S were not living in the same Unit and so any specific risk to Mr S was much more limited from that time;

(e) two incidents occurred in public areas of Pūrehurehu where it might reasonably be thought that privacy (and any opportunity to offend) would be very limited;

(f) although the other incident occurred in JC's room, there was visual monitoring of the dormitory area and the opportunities for Mr S to go (or be taken) into his room unnoticed were very limited (only if the door to the common shower room was open);

(g) the occasions on which JC managed to sexually abuse Mr S were therefore necessarily as opportunistic as they were brief; and

(h) the clinical evidence was that Mr S was not unduly distressed by the offending; his anxiety appears to have existed more around the reporting of it and the impact it might have on his desire to transition into IHC care.

[284] In the aftermath of those events JC's clinicians accepted that better management of JC was necessary, and that his behaviour ought not to have been allowed to happen. But by and of itself this does not mean that clinicians were sufficiently notified of his risk to others before-hand (given the noted paucity of the transfer documentation, for which another DHB was responsible), or that their decisions about observation of JC at various times were in breach of acceptable practice.

[285] As for what, precisely, might have been done better, when Dr Judson was asked whether it was feasible to observe and monitor patients at Pūrehurehu at all times, he said:

> Not really, I mean you had to have some times when people would probably be out of direct observations for short periods of time. It really depended upon the nature of each individual patient, in sort of fairly communal areas like the dining area which is fairly easily visible from the nursing station and all the main areas of the ward, there would have been much less individual observation of people going on I think.

[286] In my view the one question that might have been asked (but which was not) was why Mr S and JC were placed in adjacent bedrooms, given Mr S's particular vulnerability and JC's known risk. There might, of course, have been an answer to that – the most likely being that Mr S and JC had known each other for some time and there was some evidence that JC had acted protectively towards Mr S previously. Equally, however, no thought may have been given to the issue at all. That would certainly give rise to some concern. That said, however, given that only one of the incidents occurred in the dormitory area, it is only that incident which might have been prevented had their bedrooms been further apart.

[287] In short, it is not possible fairly to reach a conclusion on the available evidence about whether the DHB did or did not breach its protective duty to Mr S under s 23(5). It is notable that the applicants withdrew the negligence cause of action in that regard. As the respondents said, a finding of breach of s 23(5) is an even more serious matter (simple negligence is unlikely to be sufficient to establish breach of s 23(5)), and should not be made without proper evidence and without giving the DHB an opportunity to answer specific allegations. Breach of a fundamental right cannot be founded on some kind of "res ipsa loquitur" proposition or one unelaborated sentence in a District Inspector's report written over 15 years ago.

Failure by the DHB to provide "preventative therapy and education" or condoms

[288] This claim was not properly particularised by the applicants or put to witnesses. It is difficult to see how the failure to provide condoms to Mr S or JC had any impact on the accepted events. More general questions about sex education and the provision of condoms are addressed in the context of the fifth cause of action below.

Failure by the DHB to conduct a prompt and impartial inquiry

[289] Regardless of whether ss 9 or 23(5) could also incorporate a duty to undertake a prompt and impartial investigation of alleged breaches, it is clear from the evidence that there *was* such a prompt and impartial inquiry in this case. The investigative process disclosed by the documentary record was, in my view, timely, fair and thorough. Indeed, it found Mr S's complaints had been established.

[290] More particularly:

(a) Dr Crawshaw's file note demonstrates an appropriate immediate response to ensure Mr S and JC were separated and that Mr S's recall and evidence would not be influenced by staff;

(b) an arrangement was made more-or-less immediately for Mr S to meet with the District Inspector and the meeting in fact occurred within a few days of the original disclosure;

(c) the documents evidence that Mr S was appropriately supported in the decisions he needed to make. The process was mediated by the District Inspector (an independent statutory officer) who was satisfied Mr S was able to choose between pursuing the matter through a District Inspector or by way of a police investigation;

(d) Dr Judson's clinical view was that it was reasonable to support Mr S in making a considered decision about whether he actually wanted a police investigation, particularly as it might be frightening for him to have police involved. Ms Medlicott agreed with that assessment; and

(e) there is no evidentiary basis to reject the District Inspector's conclusion that an investigation by him accorded with Mr S's wishes.

[291] I also record the respondents' submission that the applicants' case in this respect was not, in any event, properly put. It was Mr Fairley who dealt with the investigation in his evidence but questions on the subject were directed to Dr Judson. Although the District Inspector's report was addressed to Dr Judson (in his capacity as Mr S's responsible clinician and the DAMHS) he was, as I have said, on leave at the critical time and Mr Fairley assumed responsibility for the process.

Failure by the DHB to provide Mr S with legal advice

[292] More generally, the documentary record shows that Mr S was always represented in his legal proceedings, and the evidence was that he liked to (and did) call his lawyers frequently. There is no indication he was unable to seek legal advice on this occasion if he wished to do so.

Failure by the DHB to facilitate a police complaint

[293] To the extent that this aspect of the claim suggests that Mr S should have been more firmly guided towards pursuing a criminal process, it sits poorly with a major theme of the wider claim that the applicants should have been (but were not) supported to make their own decisions about matters which affected them whenever possible. My sense is that that is exactly what happened here.

[294] In that respect Mr Fairley said that he regarded it as entirely appropriate that Mr S should have been, and was, asked for his view. He said:

> … I think that that's absolutely appropriate, and I think … you can see how carefully that was done and how the support of the staff and the various ways in which that was tested, … [Mr S] is capable of making certain decisions about himself and … he should be allowed to do that. I mean, that's about … balance between his rights and autonomy versus … not being able to consider those issues, and … reflecting back and from the notes in the report, one thing is that … the district inspector, obviously went through that pretty carefully with [Mr S] and so did our staff.

[295] Ms Medlicott confirmed that, based on the record, Mr S did have the capacity to choose between making a complaint to the District Inspector or the police. She said:

> Basing it on the evidence that I have read and, of course, not having been able to interview Mr S myself at that time, my opinion is that he was deemed to have been able to give that consent, and again Dr Bell is a highly respected clinician and those people also working with Mr S appear to have taken a very considered approach to make sure his best wishes were ascertained and then pursued.

[296] When it was then put to her that, regardless of capacity it might have been helpful to involve somebody else, such as his welfare guardian or advocate, she said:

> Again, that to me seems a little of a paternalistic approach, that the hospital is then saying despite you, [Mr S], being able to choose that you want this process that we're going to say you need to have this as well.

[297] The other thread to this aspect of the claims was the inference that there was some manipulation of the situation by staff to avoid Police involvement. I do not consider there is any evidentiary basis for that contention.

[298] Dr Judson's view was that it was staff who were best equipped to help support [Mr S] at this time and that the proposition that he might have been capable of talking to a lawyer with no staff assistance was unlikely and would have made him more anxious. He denied categorically that staff would have advised Mr S about who to complain to.

[299] It was suggested to Dr Judson (but not to Mr Fairley) that Mr Fairley had a conflict of interest because "having the complaint dealt with internally may be of benefit to the Health Services". This gave rise to the following exchange:

> A. – a district inspector is external.
>
> Q. No Nigel Fairley, he's the director of Forensic Services, it is said he's internal to the hospital system?
>
> A. Yes he is but he's not investigating.
>
> Q. No, but he's starting, he's putting in train the investigation. So at the very beginning the inspector says, "I received a telephone call from the director of forensic services advising that [Mr S] " –
>
> A. Okay. Nigel – I mean, I read that that Nigel as the director has been informed that [Mr S] is alleging some activity and that he doesn't appear to want to complain to the police but wants the district inspector to be involved. Nigel is asking the district inspector to become involved, which seems to me to be a reasonable thing to do. The district inspector is an external person and if [Mr S]'s asking for that, then that is being provided. What is the problem?

[300] And Dr Judson's evidence about the appropriateness of Mr S's ultimate choice to go with the District Inspector was that:

> … it doesn't surprise me and it didn't surprise me that that happened because I think [Mr S] would have been very, very anxious about how to go about making that complaint and how to have it investigated would have probably been quite anxious about police being involved, and it would be always better to try and keep one process rather than two so having the district inspector do that would allow a way of dealing with that in a way that [Mr S] would find comfortable and … I'm sure he would very readily choose to see the district inspector who he would already know rather than the police … whom … he wouldn't have seen … as necessarily being very supportive because he'd been obviously – you know, subject to criminal prosecutions himself previously.

[301] Dr Webb's evidence was that, in her view, this incident was a "special case in the failure of the service to understand [Mr S]'s mental capacity". She agreed that decision-making autonomy should be given as far as possible, and that clinicians who know patients well will have an important role to play in supporting clients to make their own decisions as much as possible. She also agreed that, as far as possible, patients be supported to make their own decisions by the people that they know and trust the most. She made it clear that she did not suggest that staff were doing anything but trying to help Mr S through this very difficult time.

[302] But Dr Webb did not accept that it was appropriate for Mr S to make his own decision about whether to have the District Inspector or the Police investigate his allegations. She expressed concern that there was no independent advocate made available to Mr S but nonetheless appeared to accept that the District Inspector was one such independent person.

[303] Dr Webb was also critical of the absence of a policy at the time which required serious allegations to be reported by staff in all cases to the Police. This view was very much at odds with Dr Duff's, in terms of the clinical reality of such a decision. Dr Duff said:

> From a clinical perspective then the involvement of the police will often add to the distress of the service user, the care recipient or patient. The criminalisation of the behaviour adds to the complexity in getting forward movement in placements. The way in which the criminal justice system works means that there is very long delay usually between the actual offending behaviour and any of the consequences and so that often means that there's a dislocation in terms of any learning from the experience, except the negativity of being involved in the criminal justice system. The outcomes are commonly, effectively the same, status quo, so there isn't additional involvement in that sort of way. Police at times are reluctant to therefore pursue a lot of paperwork in cases where they don't feel that there's going to be a successful prosecution on the end of it, particularly somebody who is likely to be found unfit to stand trial. We do have policies in place, obviously, that the staff are members of the public and so are the other service users and visitors to the service, so if somebody is assaulted they do have the right to take a complaint to the police, many of the staff will choose not to do so for exactly those sorts of reasons that I've described.

[304] Similarly, Ms Medlicott said:

> I think if one was to report to the police against someone's wishes, particularly a situation which may be incredibly traumatic for an individual, the person's process through the mental health process, system, that they have to go through could be significantly affected through things such as having to go through police interviews, if there's any Court case or trial, having to be a witness. It's certainly not something we would ever suggest was best practice.

[305] Overall I agree with Ms Medlicott's expert assessment that the matter was handled appropriately. She said:

> Specifically with [Mr S] I believe that the processes that were followed by the Capital Coast DHB were thorough, were compassionate, and were taking his points of view into consideration at all times.

[306] And lastly, as the respondents submitted, it is not at all clear why staff would have viewed a complaint to the District Inspector as a preferable option to a complaint to the Police in any event. The District Inspector can, and does, thoroughly investigate complaints made by patients and would have a particular focus on the clinical care and treatment of both Mr S and JC, rather than a criminal process against JC (who would, almost certainly, have been found unfit to plead). An investigation by a District Inspector is much more likely to focus on and expose any relevant systemic issues within the DHB or fault by clinicians or caregivers than a Police inquiry.

ACC claim

[307] There is no duty for the DHB to facilitate an ACC claim. The purpose of detention under MHCAT Act does not include assisting patients to exercise their property rights. Property orders are made under the PPPR Act. Mr Burgering did not explore the possibility of an ACC claim with Mr S.

Absence of an impartial investigation by the District Inspector

[308] There is no evidential foundation for this claim and I do not propose to consider it further. As noted earlier, the District Inspector's investigation appears to me to have been prompt, fair, independent and thorough. Moreover his conclusions were wholly supportive of Mr S. There could be no breach of natural justice in not giving Mr S an opportunity to comment on the draft report, because his allegations were wholly accepted by the District Inspector and the report contained no adverse comment about him.

Conclusions

[309] For the reasons I have given I am unable to find the claims relating to the assaults on Mr S made out. More particularly:

(a) there is no evidence that the DHB knew of or were recklessly indifferent to a serious and immediate risk to Mr S from JC and therefore no basis for a finding that s 9 was breached;

(b) while, on the known facts, the s 23(5) protective duty owed to vulnerable detainees is, in my view, engaged, there is (15 years on) insufficient evidence for me to form a view about whether the DHB breached that duty;

(c) once the assaults had been disclosed the DHB responded appropriately (by ensuring that JC and Mr S were kept apart and by notifying the District Inspector) and supported Mr S to make a decision about whether to go to the Police or to refer the matter to a District Inspector;

(d) the District Inspector also supported Mr S appropriately through the decision-making process;

(e) there is no evidence that any undue influence was brought to bear in the course of that process, and there were, in any event, sound clinical reasons for not involving the Police or initiating a prosecution;

(f) it is unlikely that a criminal prosecution would have been a beneficial process for Mr S or led to a more satisfactory resolution, given that JC would almost certainly have been found unfit to plead or stand trial; and

(g) the District Inspector's investigation was thorough, timely and impartial, and supported Mr S.

FOURTH CAUSE OF ACTION – REHABILITATION

[310] The fourth cause of action alleges that the respondents breached s 23(5) in that they:

(a) failed to provide a wide range of rehabilitative and therapeutic activities at appropriately regular intervals, including:

(i) therapeutic activities, such as art, drama, playing and listening to music, sport, gardening, cooking, and crafts;

(ii) psychologists;

(iii) psychiatrists;

(iv) general practitioners;

(v) dentists;

(vi) other medical specialists, including neurologists;

(vii) social workers;

(viii) occupational therapists;

(ix) individual psychotherapy;

(x) dieticians;

(xi) recreation rooms;

(xii) time to themselves; and/or time to associate with persons of their choice housed within the same detention facility;

(xiii) religious activities and/or places of worship;

(xiv) spiritual activities;

(xv) cultural activities;

(xvi) daily outdoor exercises;

(xvii) educational courses; and

(xviii) suitable work or employment opportunities;

(b) failed to provide appropriate care by the least intrusive means;

(c) denied them regular visits from family, telephone calls, the ability to send and receive correspondence, and generally failed to allow them to "maintain contact with the outside world";

(d) denied them access to a lawyer; and

(e) did not permit the applicants to leave hospital without authorisation and/or supervision.[140]

[311] The specific relief sought is a declaration that "the absence of proper rehabilitation" was a breach of s 23(5) of the NZBORA.

Preliminary comment

Scope of the fourth cause of action

[312] Many of the matters contained in the foregoing list of therapeutic and rehabilitative activities which the respondents are alleged to have failed to provide at "appropriate" intervals were not pursued in any meaningful way at trial. Other of the matters listed are addressed in relation to other causes of action (in particular access to medical and dental care).

[313] As well, the pleading that rehabilitation has not been delivered to the applicants "in a minimally intrusive way" is conceptually problematic and was not particularised. To the extent it can be inferred to relate to the use of seclusion and restraint, it is dealt with elsewhere. The pleading does not sit easily with the countervailing complaint that the rehabilitation received by the applicants is allegedly lacking in terms of both its frequency and content. But more fundamentally, it is not an issue which can effectively be mediated by this Court. The extent and nature of rehabilitation that is delivered to any particular patient is inherently a matter of clinical judgement. For these reasons, I therefore do not propose to consider this aspect of the fourth cause of action further.

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[140] There is a separate pleading of breaches of various provisions in the Convention on the Rights of Persons with Disabilities but such breaches are not separately justiciable in this Court and nor is any relief sought in that regard.

[314] Accordingly the discussion which follows will focus on:

(a) rehabilitation generally; and

(b) those specific other matters referred to in [310](c) through (e) above.

Rehabilitation

[315] In terms of rehabilitation generally, the respondents say that a duty to provide rehabilitation cannot be generally implied from s 23(5). But the respondents also acknowledge that there is an implied s 23(5) duty to meet the core statutory purposes of the applicants' detention and that, here, these indisputably include rehabilitation. It is on a similar basis that, in the context of those detained in the prison system, both the High Court and the Court of Appeal have accepted (albeit in statements that were obiter) there would be a breach of s 23(5) if prisoners were forced to "vegetate".[141]

[316] So the source of any rehabilitative duty under s 23(5) arises from a broader duty to meet the core purpose of the statutory schemes established by the MHCAT Act and the IDCCR Act, both of which have treatment and rehabilitation as core features. I therefore proceed on the basis that a failure to provide the applicants with opportunities to engage in treatment or rehabilitation could amount to a breach of s 23(5).

[317] But the accepted existence of such a rehabilitative duty does not make the treatment and rehabilitation that has (indisputably) been provided to the applicants susceptible to close judicial supervision. I agree with Mr La Hood that such a duty must wholly be met once DHBs have made treatment or rehabilitation of an acceptable clinical standard available. Beyond that, there can be no scope for the Court to make judgements about or to second-guess the quality or frequency of what are, essentially, clinical decisions made by experts.

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141 *Toia* (HC), above n 118, at [105]; *Toia* (CA), above n 118, at [49].

The relevance of changes over time

[318] There was simply no evidence to suggest that acceptable clinical practice was not followed in the treatment and rehabilitation of each of the applicants over the years. Indeed, my overwhelming sense was that the treatment and rehabilitation they have received was individualised, humane and proactive. As noted earlier, all the clinicians who gave evidence at the trial came across as dedicated to the applicants' well-being and committed to supporting them to transition back into the community.

[319] That said, however, there can also be no doubt that there have been changes and improvements in the delivery of intellectual disability services over the period covered by the claims. That was acknowledged by a number of the respondents' witnesses. By way of example only, Dr Duncan said:

> I think that what's happened over the last ten years is that we have been working steadily to ensure that the staff have more and more mindful practice rather than just turning up and doing the job and that they see themselves as they are the therapy. That, you know, they're a therapist doing the therapy. The interactions they have with staff on the floor are the therapy and we've had development of quite a lot more education. Paul Oxnam and Emma Gardiner have introduced coffee, cake and chat which is group supervision for the support workers. We have got a lot more focus on staff understanding that the way they interact with people is, is what makes the difference.

[320] And more specifically, in relation to a question about whether Mr S, has a "more proactive programme" now than he had had before, Dr Duncan said:

> Yeah I think it is more, it's more nuanced anyway. The, the training of staff has been quite intensive over the years. People are better at looking at proactive approaches to managing people with episodes of challenging behaviour as opposed to the more reactive way that they were being managed earlier and that's not just, that's not just here. That's everywhere. There's been more and more focus on proactive management, over the last 10, 15 years at least. I've been going since 2008 to International Learning Disabled Offenders Conference in the UK and interestingly this year was the first time that Good Lives, and positive behaviour support featured at all in the programme, whereas we've been working with good lives and positive behaviour for, I don't know, five, six years and gradually developing things. So in that sense I think, you know, we're ahead of the curve and things have changed incrementally over time.

[321] A similar, but more general, point was made by Ms Daysh, who said:

> ID [intellectual disability] services as a whole are evolutionary. They change all of the time. We look at services in different ways, so we look at

> environments, do environments change across time? Environments do change as technology allows us to change, buildings will change, but the buildings that you've seen in the last couple of days have not … changed substantively over that period. … With respect to policy and practices and staffing, those things do change over time because we become more aware and more educated but with respect to things like care and rehabilitation plans, they have been available since 2002 and 2003, those things haven't changed substantively … . In terms of our care staff, we have been able to focus over that decade and slightly longer on more ID specific training because people came from psychopaedic institutions with psychopaedic training and that has been lost and so we have had to then refocus our training so that we have ID specific training built into all of the services that we run. So those things have evolved.

[322] And in response to a question about whether the rehabilitation programmes on offer today were offered when the Units first opened, Dr Judson said:

> Not in as systematic a way as it is now. I think there's been a gradual development of and refinement of the kind of programmes, you know there are I think four psychologists in Haumietiketike. I mean that's a lot of people, including the two clinical leaders which I think has put the emphasis where it should be, which is about behaviour and managing behaviour rather than a medical focus.

[323] One specific example of rehabilitative changes over time which was the subject of a good deal of cross-examination related to the use of what is known as the "positive behaviour support" (PBS) model for addressing "challenging" behaviour. The use of that model was very much advocated by Dr Webb, who was critical of the respondents for not adopting it sooner, or more fully. She explained:

> Historically, there has been a noteworthy evolution of responses to challenging behaviour.
>
> The most common responses to people with challenging behaviour in the institutional settings have been seclusion, restraint and sedating medication often combined with aversive strategies that are based on the false assumption that if you follow undesirable behaviour with an aversive event or punishment, then that behaviour will permanently reduce.
>
> Internationally, these strategies have now been either totally rejected or tightly controlled. In New Zealand the Ministry of Health has set national standards relating to the use of restraint (including chemical restraint) and seclusion. In Australia each of the States has also established a position of public advocate to further manage and ensure that service providers use least restrictive practices at all times. In all states, the use of punishment or aversive procedures has been outlawed.
>
> These unacceptable practices are now replaced by 'positive behaviour support', or the use of positive reinforcement schedules that:

1. Behaviourally identify the unacceptable behaviour

2. Identify a new behaviour that would service the same function as the unacceptable behaviour

3. Gradually teach the new behaviour and when it should occur

4. Institute cues and prompts to ensure the behaviour occurs

5. Positively reward the new behaviour whenever it occurs and ensure that it achieves what the old behaviour achieved.

[324] A major theme of Dr Webb's evidence was that the respondents continued inappropriately to preference punishment, seclusion and restraint when dealing with the applicants instead of this more positive model.

[325] But Ms Medlicott explained the development of PBS in this way:

> The term "Positive Behaviour Support" has really only become – with capital letters … part of the disability focus over the past five years or so. In Victoria they released the guidelines in 2011 … The original writings on Positive Behaviour Support, such as from Keith McVilly, do date back to 2002 but these were early on … it's only been the last five or six years that we've had Positive Behaviour Support as the programmes that we'd work with.[142]

[326] Ms Medlicott also explained that positive support and proactive strategies aimed at encouraging and motivating people to change their behaviour and to build their skills has been going on since the 1970s and (she said) has certainly been part of the strategies that were put in place for the applicants. She emphasised that while those strategies might not have been called "Positive Behaviour Support" the behaviour management plans, nursing managing plans, reward programmes and so on were all non-aversive, or the least aversive possible. Ms Medlicott went on to explain further that, the extent to which such "positive" models could be used in an individual case was, itself, evolutionary:

> Standard clinical practice was always positive. It was always trying to be motivational. It was always around skill building, acknowledging the need for reactive practices to go alongside that. But the goal of this was to help people have greater internal skills, to be able to manage emotional distress, to be able to manage difficulties and interactions with other people. So when people would initially come into the units they would usually be because they were, had very limited internal skills and needed those external constraints around them in order to maintain safety. So over time, work would go on,

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[142] Similarly, Dr Duncan's evidence was that PBS did not feature at the international conferences he regularly attends until 2015.

> positive framework, to motivate and build and upskill people so they were no longer presenting with such significant risk.

[327] Ms Medlicott's point (that much of the thinking underlying the PBS model has always been present in the treatment and rehabilitation of those such as the applicants) was confirmed by many of the clinical witnesses of fact. For example when Mr Oxnam was being question about was a document he had written in 2008 (called "Guide to Working with [Mr S]") he said:

> I think in the last few years I've become more attuned to what you might call the Positive Behaviour Support brand, perhaps, that is, when it's spelled with capital P, capital B, capital S. So how Positive Behaviour Support might be delivered in that context perhaps isn't reflected in what we were doing at that time but the principles of a Positive Behaviour Support approach I think were represented, so the emphasis on fostering a person's quality of life, giving them enjoyable things to do, having a good grasp of why they're presenting the way they are, giving them opportunities to do things like Special Olympics and spend time with family and doing fun things for the sake of doing fun things rather than having to necessarily earn them. So emphasis on normality rather than institutionalisation, plus we also had what we would call reactive strategies, so steps we would need to take to support [Mr S] when our proactive strategies didn't, weren't as effective. So … I do think that we were consistent with the principles of Positive Behaviour Support but … the document doesn't necessarily, isn't necessarily written in a way that reflects that Positive Behaviour Support brand per se.

[328] Mr Oxnam said that, in his view, the "Guide" was consistent with PBS principles and was clearly aimed at encouraging independence and quality of life.

[329] Similarly, Dr Duff's evidence was that there was considerable emphasis on positive reinforcement within the Pōhutukawa Unit. She said

> … we had an applied functional analysis system. We had token economies and star chart systems. We … have behavioural management plans in place. We also had other therapeutic interventions such as strengths-based and skills-based training such as the use of dialectic behaviour therapy in its adapted forms. So we had a number of other positive approaches to challenging behaviour but they wouldn't … all come under the criteria defined in specifically a positive behavioural support approach …

[330] In terms of the conclusions that can be drawn from this and the other evidence I heard about PBS, I agree with the respondents that:

(a) PBS is one particular approach to rehabilitation;

(b) there are other clinically acceptable approaches to rehabilitation, which incorporate aspects of the PBS approach without subscribing fully to its 'brand'; and

(c) care at both Haumietiketike (and its predecessors) and at the Pōhutukawa Unit has always incorporated aspects of a PBS approach.

[331] Dr Webb also accepted that implementing a 'pure' form of PBS is "more difficult" within a secure forensic facility than outside a detention setting.

[332] But the wider point is that ideas about the delivery of forensic services and best practice in terms of rehabilitation and treatment may differ. They necessarily evolve over time. The respondents did not deny that there have been changes and improvements in the care given to the applicants over time. Indeed, it would be concerning if that were not so. Those improvements are, in my view, largely attributable to a combination of the following:

(a) the fact that at the beginning of the claim period, prior to the enactment of the IDCCR Act, there were no specialist forensic intellectual disability units in New Zealand and (accordingly) the conditions under which the services were delivered to the applicants were less optimal and the services themselves were less ID focused;

(b) the inevitable increase over time in terms of the relevant clinicians' knowledge and understanding of the complexities of each of the applicants and their disabilities; and

(c) more general philosophical shifts (that are not confined to New Zealand) about the best approach to rehabilitation and treatment of those such as the applicants.

[333] It is of course possible to say that it would have been "better" had Parliament enacted the IDCCR Act before it did and had the Haumietiketike and Pōhutukawa Units been opened sooner. It might also have been "better" if the clinicians had

understood the applicants as well as they do now at the time they first came under their care. But this claim cannot be determined by reference to circumstances that did not and could not have existed. In the absence of any specific expert evidence that the treatment and rehabilitation provided to the applicants was, judged at the time, non-existent, negligent or somehow substandard, this aspect of the claim cannot succeed.

What services are provided?

[334] The services provided to the applicants have focused on both rehabilitation and "habilitation". The term "habilitation" is used to describe the teaching of skills that people have not yet acquired, as opposed to re-learning previously learned skills. That habilitation is required as well as rehabilitation is a necessary function both of the applicants' disabilities and their disrupted, and often adverse, childhood experiences.

[335] The evidence overwhelmingly was that, subject only to the risk they might pose to others at the particular time, the applicants have had regular access to a wide range of rehabilitative activities and programmes. These activities and programmes have included (amongst other things) gardening groups, individual psychiatry and psychology sessions, family visits, leave to go shopping, art therapy classes, pet therapy classes, anger management classes, sport activities, voluntary work, cooking skills classes, cultural activities, and church visits.

[336] In terms of the range of programmes on offer at Haumietiketike, Dr Judson commented:

> …there's a lot of good programmes going, people are getting out a lot, there are days when there's hardly anybody actually in the unit at Haumietiketike because they're out doing things which is always great. It can be difficult as a doctor to find people sometimes when you need to see them but that's good.

[337] The Ombudsman's 2014 report on Haumietiketike contained a similar comment.

[338] By way of example, Dr Judson spoke about the day programme at Ratonga-rua-o-Porirua, known as Te Maara. It includes a gardening programme which has been set up at the old Bowling Club at Porirua Hospital. Patients grow and harvest produce on the old bowling green and then use the produce to prepare meals with

assistance from staff. There are chickens which produce eggs which are sold by the patients. They also use the old bowling clubhouse for other occupational activities and social events.

[339] Ms Daysh said that there was a balance between individual and group activity:

> … almost all patients under the high and complex framework will have had group therapy options but many of them will have had individualised one-on-one programmes or therapy with psychiatrists and psychologists and other counselling professionals.

[340] In terms of individualised care, she said:

> … each of them have highly individualised care and rehabilitation plans drafted for them and whilst they are written in a standardised template, the information contained in them is wholly specific to the person that that care plan is drafted for and rather than person-centred we tend to call them individualised.

[341] That the applicants themselves have been given programmes, activities and plans which are tailored to them personally, with a view to furthering specific skill development and moving each of them closer towards transitioning to community care was made clear in the evidence of the relevant clinicians. Thus:

(a) Dr Duff gave evidence about Mr M's treatment programmes and behavioural plans. These included Needs Assessments, his Health Care Plan, his Behavioural Management Plan and his treatment plan. She also gave evidence about Mr M's Individual Care and Rehabilitation plans in accordance with the IDCCR Act. There was evidence about the individualised way in which this treatment was provided.

(b) Dr Duff also gave evidence about Mr C's treatment programmes and behavioural plans. As with Mr M, for the duration of Mr C's detention in secure units, he has had an overarching care and treatment plan. There have also been many Comprehensive Clinical Summaries, and management plans (including risk management plans).

(c) Dr Barry-Walsh described Mr S's Treatment Plans and Management Plans. His Treatment Plan identifies the key treatment areas or the

> desired outcomes and then sets out the actions designed to achieve that treatment or outcome. His management plans are designed to promote consistency of care and to maximise Mr S's therapeutic environment. Mr S's Risk Management Plans identify 'early warning signs' that, in the clinicians' experience, have often preceded an episode of aggressive or agitated behaviour. The plan then sets out recommendations for intervention or management. The purpose of these forms is to prevent early warning signs from developing into episodes of aggressive or agitated behaviour, and to provide a consistent response when dealing with such an episode. This is important to ensure Mr S is safe and also to ensure the safety of other patients in the unit and the staff. Risk Management Plans also identify current risks and safety issues and also set out recommended interventions.

[342] Both Dr Duff and Dr Barry-Walsh discussed the multi-disciplinary approach to the care and rehabilitation of each applicant. Those teams were generally made up of a psychiatrist, a psychologist, nurses, occupational therapists and social workers.

[343] Patients are, however, given choices about the types of programmes they want to engage with:

> … because they are adults they will make choices themselves about the focus of the activities they want to gain skills in and some of them will want what they would consider more practical skills. Some of them don't necessarily want to engage in numeracy and literacy programmes, some of them would prefer to engage and spend more of their time perhaps in the horticulture programme or as one patients suggested to us, that we could offer a course in stripping down cars, but they have their own ideas about things that they wish to focus their attention on.

[344] There can, of course, be a tension between giving patients choices and their rehabilitative needs. For example Dr Barry-Walsh's evidence was that, at times, one of the biggest challenges identified by Mr S's care team was getting him to participate in activities at all. That was confirmed by Mr Oxnam who said that Mr S would often tell staff that he did not want to attend the "Stepping Stones" programme and staff would then spend time encouraging him to go. He would continue to refuse, but then at the last minute go along. That was a pattern which continued for years. But staff

continued to encourage Mr S to participate in groups, and rewarded or incentivised his increased participation.

[345] As noted earlier, the evidence was that the programmes offered have always been "proactive" in terms of trying to prevent incidents of aggression or anxiety, and encouraging patients to transition out of compulsory care. One example described by Dr Duff involves the use of "social stories":

> Social stories are a particular way of communicating, particularly with people with autistic spectrum disorder. Social stories involve effectively creating a predicable scenario that allows the person to understand what's going to happen in the future because of the difficulty in anticipating or predicting what's going to happen in the future for somebody with autistic spectrum disorder. But actually, social stories – they're a way of putting things into context, explaining them, "If this happens, then this happens, then this happens," in simple ways and repetitively …

[346] Necessarily, however, there are also plans for when challenging behaviours do present. Although Dr Webb suggested that these responses tended to be inappropriately punitive or aversive, that was rejected by the clinical witnesses as insufficiently nuanced. Dr Duff put it this way:

> So the line between what is a reinforcement and what is provided as a reward or an encouragement for us to behave in a particular way and what is perceived as a punishment, is often perhaps one of perspective as well, so for example if I failed to turn up at work there will be a consequence to that, I will lose my job, it's not a punishment, it's a consequence. If I turn up at work every day I get paid for that and that's reinforcement that helps me on rainy Mondays to say it's worth getting out of bed, I should go to work and so the taking away of, the fact that if I don't turn up to work and I don't have a good excuse for it I might be docked a day's pay as punishment, it's well I didn't work for it so I didn't get it[.] [A]nd so for example bringing it back to the men where particularly there's been a significant incident, items may have been removed from the room in terms of safety. The incentive then to earn those back by being able to display that you're in a safe or wise mind and able to manage that safely has the double benefit of both meeting safety requirements but also giving somebody something to work for to maintain the behaviours that you're hoping to see extended. So yes, …it's not intended as punishment and it is important to keep reminding the staff of that as well because we're human beings and human beings will have that sense of fairness as well and asking the staff to put that aside and behave only consistently with a plan is something that does need reinforcing, reminding and support for the staff team as well because they might be on the receiving end of extremely abusive behaviour for extreme periods of time as well and therefore that's good to have something like as a statement, as a reminder to people this is not about punishment. And punishment is, we know behaviourally is very ineffective, that positive reinforcement's much more likely to be effective as a strategy and that's one of the ways round that big ask as well.

[347] It became apparent that Dr Webb's conceptualisation of what constituted "punishment" was different, and rather broader:

> There's a fundamental piece of understanding that has to be captured. If a behaviour by any person is followed by a behaviour that is in, somehow aversive or noxious, whatever you like to use, then that action is a punishment. Now, what I have heard and seen people saying is they did these things for reasons of safety, and the definition of punishment doesn't include the intent of the person. It's quite different. So that if you grab a child who threatens to run out under a bus, and heave them back on the pavement, you're doing it for his safety. The action is actually punishing to the child, because it is a negative potentially painful action that is, that occurs immediately after his running out behaviour.

Range and frequency of activities

[348] Dr Webb relied several times on a statistic that patients were engaged in rehabilitation for only 20-30 per cent of their time. That statistic appears to have no foundation in the evidence.

[349] It was also put to the respondents' witnesses that there was a problem with "boredom" within the Units. Dr Duff was asked what had been done to "alleviate" this at Pōhutukawa. She said:

> Heaps and heaps. You've seen the standard programme of activities, so there's quite a structure to the day. It's quite rhythmic. There is a lot of interactions with staff, so besides your core skills, educational, creative activities that go on we also have the visiting dogs from the SPCA, we have chaplaincy and church services, we have a Māori cultural team coming in, we organise leisure and interest activities in the evenings, we have bingo nights and ping-pong and a pool table and indoor bowls. We do karaoke nights. We have movie nights. So we try to keep as many things going on during the day, during the week, as we possibly can. Because people do stay for quite lengthy periods of time at times then those programmes aren't completely repetitious, so we try and change the focuses. We work very hard to make it seasonally themed or around certain holidays, Matariki, we'll have a set of activities associated with it as will Christmas. They'll decorate the units for themselves. We have cooking groups. We have outings. We have visits. So we do try to fill the week with really quite a lot of structured activities and leisure activities and creative activities of various sorts.

[350] When then asked how could it be "better", the she said:

> It's difficult to see how much better it could be, actually, within the confines of the restrictive orders that people are under.

[351] Importantly, the applicants themselves described the types of activities that they do, or like to do, on a daily basis. Mr C (who remains in secure care at the Pōhutukawa Unit) described a typical day which included going for a walk, having the SPCA come to the Unit, cooking group, playing cards, and watching television. He discussed those matters in more detail with Ms Medlicott, who reported:

> Mr [C] enjoys a fairly structured day, waking up at 7.30am and having breakfast in his cluster at 8am. He noted that he usually has cornflakes for breakfast and would like coco-pops. Vaughan said that if he wanted them he could buy them anytime. He showers and dresses independently and is always able to choose his own clothes, again noting that he likes to keep himself and his belongings "nice and neat". He meets with his staff to discuss the plans for the day, including alone time, which he draws on the whiteboard. He noted that he used to have a visual plan drawn for him but he prefers the system that he has now. [Mr C] attends the unit community meeting on Mondays, and in the afternoons will often join in with various groups, such as the news group. [Mr C] will then spend some time playing many games of Last Card with staff and other consumers, will write letters, or whatever he wants to do, noting that it all "depends". He said that he often has a morning "snooze" after his medication, which he enjoys. He said that he loves playing volleyball and attending the community groups in the creative room. He sometimes attends the literacy group and noted that he was working on adding up. He enjoys the meals at the unit and particularly likes the puddings on Tuesday, Thursday, and Saturday. He also noted that he is participating in some cooking, and has recently made macaroni cheese, shepherd's pie, tuna salad, and egg sandwiches. In the evenings he may join in with others on the unit to play Bingo (on Fridays), go swimming, play volleyball, and/or attend the relaxation group. He particularly enjoys watching television and has a subscription to the TV Guide and will mark what he wants to watch on it each week.
>
> [Mr C] then discussed upcoming trips from the Pōhutukawa unit, including the plan to see The Jungle Book the following Tuesday, going shopping, and going to "Point Chev". He noted that he was looking forward to getting some new headphones so he could listen to Faith Hill. He then discussed some other preferred activities, such as his frequent walks around the grounds of the Mason Clinic. He discussed going to the slides at the Parakai pool, and how he enjoys daily use of the pool on the grounds in summer, noting that it was an outdoor pool and too cold to use in winter. He also discussed outings such as to the Zoo (where he particularly enjoyed watching the elephants) and MOTAT [the Museum of Transport and Technology], Butterfly Creek, and going plane spotting. [Mr C] also discussed going on a train ride to Swanson in the Waitakeres.

Transitioning to the Community

[352] Assisting in the transition from (secure) compulsory care into community care is recognised in the NZ Core Standards as an important part of a patient's care in mental health services, including within the National Intellectual Disability Secure

Services (NIDSS).[143] Facilitating such transition is necessarily one of the focuses of patients' habilitation and rehabilitation.

[353] Ms Medlicott explained that the processes of transition become increasingly complicated when a person is required to be detained in a facility such as a NIDSS service, and is even more so when the he or she presents with multiple diagnoses and the presence of intermittent aggression or other concerning behaviour. She said that in order for a transition to have the greatest likelihood of success, particularly for a person who has lived for a number of years within a hospital-based service, there are a number of steps that need to be taken. The patient concerned should be working actively on various rehabilitation tasks, including developing or enhancing day-to-day living skills, identifying and appropriately managing distressing emotions and associated behaviours and, ideally, becoming more self-reliant. In addition, there should be ongoing education and training of staff in the community so that the most effective and robust services are available.

[354] Ms Medlicott said that in order to address risks associated with transition, the community service provider will often identify a staff team who are involved in training and working alongside the patient in the inpatient unit, prior to the move. Conversely, staff from the inpatient team will sometimes work alongside the service provider with the patient in his or her new home. It is not unusual for transition from an inpatient unit in to a placement with a community service provider to take up to 13 weeks. In some instances, there may be multiple visits to a service provider's home, with an increasing number of overnight stays, before complete discharge from the inpatient service is considered.

[355] Ms Medlicott also emphasised said that not every transition of a NIDSS patient is able to be sustained over the long term. There are some that go well for a while, but then the patient's behaviour may overwhelm the capacity of the provider to manage him or her safely. At those times the patient will generally be redirected back to the NIDSS. Sometimes the community service provider will withdraw the offer of a placement. At other times the provider will remain engaged and will participate in

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143 *Health and Disability Services (Core) Standards* NZS 8134.1:2008, Standard 3.10.

future transition attempts. Ms Medlicott stressed the importance of using any transition that has not been successful as an opportunity to identify what needs to be done to maximise future success. Ms Medlicott noted that recent audits of both the CCDHB and WDHB policies and processes around transition meet the required standards and that the step-down cottages at Haumeitiketike could be seen a significant positive step in helping the transition process.

[356] Throughout their DVD interviews, the applicants referred to their desire to live in "the Community" and that it has taken too long for them to be transferred out of compulsory care. But the applicants' perception of what living in "the Community" meant, was interesting:

(a) Mr M criticised the Pōhutukawa Unit because the programmes there "don't help people get back in the community". He said, "There aren't any programmes or the programme doesn't work". That statement is, of course, belied somewhat by the fact that Mr M has now been released from compulsory care and now resides in supported care in the community.

(b) When asked where he would like to live if he could choose, Mr C said he would like to live "in a community". He said that would be good because he could "do things". He noted he would need to have his own phone and that he would want to live with a flatmate. Good things about living in the community included cooking dinner and going out with friends. He said to Ms Medlicott that he would need support staff to help him with things such as managing his money and cooking. He said he would like to be in the community by the time of his "big 5-0".

(c) Mr S (who is presently living in one of the step down cottages at Haumietiketike) spoke about how he would like to live in Whanganui because that is where his family is. When asked what sort of support he thought he would need to live there he said: "Like the cottages, like all their all their night lock doors, sort of the same situation". He said

he would need staff. He made similar comments to Ms Medlicott, who recorded him as saying that:

> ... he would be particularly happy if a cottage identical to the one he is currently living in could be built close by on the grounds where he and others with ASD (with or without an intellectual disability) could be supported by staff who either also had ASD or who had a good understanding of ASD. When asked if such a service could be run by the CCDHB or from an outside agency he replied that it would need to be an outside agency, although when asked was unable to identify anything that an outside agency would be able to offer that could not be offered by the CCDHB. He then stated emphatically that he "likes it here" (referring to the cottage he is currently in). He noted that he likes his flatmates and enjoys being able to make a cup of tea when he wants one. He said that it would be scary to be in the community away from Ratonga-rua-a-Porirua.

[357] Dr Barry-Walsh gave evidence about the many unsuccessful historical attempts to transition Mr S to the community and Dr Judson gave evidence about the extensive plans that were put in place to facilitate his move to the cottage. He said that the level of detailed commitment shown by staff to that aim was exemplified by one occasion where eight clinicians discussed in detail whether Mr S would be comfortable changing the night he gets takeaways to align with the other residents in the cottages. Dr Judson also described how some staff members who knew Mr S well were seconded to the cottages so Mr S would have a familiar support group there, and how they arranged for the other residents of the cottages to invite Mr S over. Although staff continue to work on ultimately helping him move to the community, he said that the present reality is that despite Mr S often talking about wanting to move out of the hospital, he gets very anxious when there is any discussion about this.

[358] Similarly, Dr Duff gave evidence about the considerable efforts gone to by staff to transition Mr M to community accommodation. While there can be no doubt that Mr M himself was frustrated that the process took so long, Dr Duff's explanation about why the transition was slow was compelling. It is confirmed by a report from a Special Assessor (John Nuth) dated 2 October 2012 where he stated that:

> ... [Mr M] would appear to have made excellent progress in order to make the transition to life in the community; however it should be noted that this has taken considerable resources, flexibility and commitment on the part of agencies in order for this to occur. For

> example, staff at the Pōhutukawa Unit were released from their rostered duties at the Mason Clinic in order to work closely with [Mr M] and staff at Tīmata Hou. [...] Understandably, given [Mr M's] complex presentation (and history of anxiety and agitated behaviour), this has not been without its difficulties. [...] One should therefore not underestimate the considerable efforts and ongoing supports that have been required to get [Mr M] to this current situation.

[359] Mr C, on the other hand, remains at Pōhutukawa. The evidence was that he continues to present particular challenges for staff and for a transition process. But Dr Duff spoke of his incremental improvement in the face of those challenges. She discussed the relatively recent, successful, use of "social stories" to help Mr C to understand cause and effect. His furniture no longer needs to be fastened to the floor or walls because he no longer throws it at staff. Mr C has become increasingly communicative and there has also been a decrease in the number of occasions where Mr C becomes angry to the point of being assaultive, although incidents do still happen. He now knows that if he is feeling angry and aggressive to stay behind his "invisible line" and so very rarely comes out of his "safe area" to assault others. Mr C also now spends much more time out of his "safe area" and returns to it only when he does not want to spend time with others.

Contact with the outside world

[360] Visits, telephone calls, correspondence and access to lawyers are all guaranteed by the MHCAT and IDCCR Acts, but may be limited where patients' interests require it.[144]

[361] Most of the allegations relating to these matters were not put to witnesses and can fairly be treated as abandoned. I nonetheless deal with what remains of the claims as best as I am able.

Correspondence

[362] Certain allegations relating to Mr M's correspondence made in the Statement of Claim were not pursued at trial. They were, in any event, answered by evidence called by the respondents and I do not consider them further. Another specific issue

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144 MHCAT Act, ss 70, 72 and 73; IDCCR Act, ss 11, 54, 56 and 57.

relating to Mr S's correspondence will be addressed later, as part of the sixth cause of action.

Visits

[363] The applicants allege that they have been denied the opportunity to maintain contact with their family, friends and advocates. Two general points can usefully be made at the start.

[364] First, and unsurprisingly, there are differing levels of engagement as between different patients and their families. Some have families who are very involved in their care and who visit regularly. Some have family members who are also their welfare guardians, so have a formal involvement as well. Others specifically request no contact with their family due (for example) to past abuse within the family or because the patient has committed offences against family members. And so it is in the present case, where Mr M has little or no contact with his family and, indeed, no issue was taken about that. Mr M does not, therefore feature in the rest of the discussion under this heading.

[365] Secondly, there are sometimes practical limitations on, and variations between, such visits:

> … we balance [family visits] against the primary purpose of people being in the Mason Clinic in Pōhutukawa Unit, which is to complete rehabilitation so that they can move to less restrictive levels of care. At various times in the past we've had various regimes for visitors and generally visits are held for weekends and generally on a weekly basis, therefore for people who have accessible families or visitors from outside of the unit. In addition, families who are coming from further afield or special occasions or special activities may also have additional, more frequent visits so, for example, if we have somebody who's come from out of town and is staying in the whānau flat at the Mason Clinic they might have three or four visits over the course of a weekend whilst they're there. So it's not hard and fast, what we would consider to be reasonable.

[366] But more specifically, and as far as Mr S and Mr C are concerned, no evidence was called from any family members in support of the allegation that visits had been denied or restricted. Indeed, in their DVD interviews:

(a) when Mr S was asked "… do your sisters come and visit you here?". He replied "I see them all the time";

(b) when Mr C was asked whether he had any people that come and visit him. He listed "My dad. Friends. Yeah. Iona. The Doctor". He said that he did visits "Every fortn…, every couple of weeks". When his dad visits, he brings goodies. Mr C also said he had other friends from Auckland who visit him at the Unit.

[367] The late Mr Burgering himself gave evidence that he was each applicant's "advocate" and had had a close relationship with them all for a number of years. He gave no evidence of concerns that he had not been able to contact the applicants on a regular basis. On the contrary, his evidence was that he had been closely involved with them for more than ten years.

[368] Nonetheless, I will say a little more about visits, in relation to both Mr S and Mr C, in turn. In both cases, the nuances and practicalities around the issue are well demonstrated.

Mr S

[369] Mr S's main family contact has always been his sister, who is his welfare guardian. He now visits her once a month in Whanganui. Dr Judson explained that this would not have been possible at an earlier point in time:

> So I mean, for example, his monthly visits up to see his family was something that didn't use to happen back in 2004. It wouldn't have been possible to consider that for safety reasons, whereas that now happens on a regular monthly basis and initially that happened with a particular member of staff who had established a really, really good trusting relationship who was prepared to undertake that trip and has gradually been able to be taken up by some other staff who've developed the trusting relationship…

[370] Dr Judson also said that, in the past, Mr S tended to become agitated prior to visits:

> … Where [Mr S] has someone due to visit him, whoever it is, or a specific event coming up that he becomes – there's a risk of him being less regulated. So that's baseline. It doesn't matter who it is or what's going on. But yeah,

> there was also the issue of whether necessarily what was being discussed or proposed by them was in his best interests or, in my opinion, the best interests of the system we were trying to manage, trying [to] run …

[371] As well, Dr Duncan explained particular historical concerns about the impact that visits from advocates sometimes had on Mr S's rehabilitation. In particular he voiced concern that, on occasion, advocates were pursuing their own agendas at the expense of Mr S's well-being and, on others, that they were giving him unrealistic expectations about the future. He said:

> … you'll notice that one of the things that was happening there that I felt was unhelpful was that there were many times when [Mr S] was saying that you know, he didn't have to listen to what any of us said because he was going to be out of here soon and he was gonna be employing us and he was going to be running the unit so he didn't have to listen to us and I didn't really think that was – I could understand why that might be seen by people as giving him hope for the future but I didn't think that it was a useful tack to be taking with him in light of his particular vulnerabilities and difficulties.

[372] Dr Duncan's evidence about this was supported by Dr Barry-Walsh who spoke about a specific period in April 2007 when he directed that Mr S was not to have contact with the Mr Burgering and another advocate, Mr Greally, on clinical grounds. He described how Mr S's mental state had deteriorated at that time and that contact with the two advocates had, in his clinical opinion, made it worse. But once matters improved (the following week) he rescinded the direction and permitted Mr S to have supervised access with Mr Greally and Mr Burgering again. Dr Barry-Walsh recalled:

> This was quite an issue, as I recall it, with [Mr S] that at times he would get very anxious, very focused, and would visibly deteriorate around visits and that happened to the degree that at this time I felt that was a clear need to exercise section 72. It's not a decision I took lightly. It's one that I clearly reviewed at least weekly and it would always be my practice not only to notify the DAMHS but also to discuss it with them and it would have been a decision that would have been made in conjunction with the treating team. No clinical decision I would make I would make on my own. In fact, I discussed it with the District Inspector and with his sister as well.

[373] Dr Barry-Walsh categorically rejected the proposition that there might have been an alternative explanation for Mr S's behaviour at this time (such as "some cyclic event in his illnesses"). He said:

> … when these events would occur we'd always carefully analyse what's going on for [Mr S] and my memory is that it was very obvious that it was this contact that was driving this episode. I can't tell you much in the way of

> specifics other than Mr S became very preoccupied. I think at one time he expressed a high level of hostility towards one or both of these gentlemen, as well, but my memory is that it was a straightforward observation.

Mr C

[374] Mr C's principal visitor is undoubtedly his father, who has been regularly involved in his son's care for many years. He was spoken to by Ms Medlicott, who recorded:

> [Mr C senior] stated that since [Mr C] has been at the Mason clinic he has had the best support he has ever had. He stated that he cannot fault the care he is being given, and is particularly impressed by the work put in to get him off the "cocktail of medications" he was on prior to coming in to the care of the WDHB or CCDHB, to the medications he is current receiving. He stated that when he visits his son he can now have a "great conversation" and positive interactions.

[375] Dr Duff spoke about the importance of Mr C's father's involvement in his son's care and emphasised the importance to Mr C of predictability in terms of contact:

> So the importance of … regularity was discussed alongside the diagnosis with [Mr C Snr] and he's been an absolutely stalwart person. Rain or shine, sickness or high days or holidays he pretty much – he phones on the Friday, he says whether he's coming on the Saturday or Sunday every fortnight and maintains that rhythm which is great because it's nicely predictable for [Mr C] who no longer worries about these at all. He tends to worry about his mum because the phone calls are more random and unpredictable and even if they're, so the unpredictability causes the anxiety intrinsically because it's unpredictable not because it's necessarily unpleasant so Christmas for example, the rhythms become unpredictable in a nice way, he gets treats and nicer food and decorations go up and presents happen but actually that causes anxiety as well because it's unpredictable.

Telephone calls

[376] Mr S's specific claims relating to telephone calls to his lawyers and Mr Burgering under the sixth cause of action have been withdrawn, but the general fourth cause of action claim remains, pleaded as an aspect of "rehabilitation". The only matter raised by the evidence to which this pleading could now relate is Mr S's telephone plans.

[377] Dr Duncan gave evidence about particular challenges arising from Mr S's unregulated use of the telephone and the policies put in place to regulate (but not to

eliminate) that use. He explained those policies were put in place so that Mr S had a clear understanding of the rules around the use of the telephone which, in turn, helped to manage his anxiety around unanswered phone calls, taught him skills for appropriate phone usage outside of the hospital environment, and protected call recipients from near constant phone calls, which also protected Mr S's relationship with those people.

[378] By way of summary of the plans, Mr S was essentially permitted to call people a certain number of times and, if they were not available, he could leave a message, but was required then to stop calling. When it was put to Dr Duncan that that plan had an adverse effect on Mr S's agitation levels he said:

> Well, I think you've said the other way round there. The issue is if he tries to get through to someone and he can't get hold of them, how does he feel? He feels upset, and the more he can't get through to them the more upset he will get than he often – but his tendency is he can't then say, "I'll wait and I'll try later." He wants to keep going over and over again, and that's why the plan was introduced feeling that it was a lesser of two evils situation, that it was less – it's going to be less of an issue if that was terminated after a couple of attempts to get through rather than waiting till the inevitable spiral that would happen if he continued not to be able to get through to someone.

[379] And when it was also put to Dr Duncan that Mr S's phone calls were likely to have been prompted by unhappiness with his circumstances and a desire to talk to somebody about that, Dr Duncan's response was:

> Not necessarily unhappy. He just wants to talk to someone and often if he couldn't talk to who he wanted to talk to he'd talk to someone else, you know. He is a peripatetic butterfly who flutters from one to another.

[380] Overall, Dr Duncan said that, in his clinical view, the plans were a necessary and appropriate response to Mr S's particular vulnerabilities and difficulties, and were consistent with the MHCAT Act. I agree.

Access to lawyers

[381] In general terms, the documentary evidence strongly supports the respondents' position that each of the applicants has been represented by various lawyers throughout their court processes and have had contact with lawyers when they wanted it. Ms Daysh commented that the (high) level of support from lawyers as seen

throughout the records in this case is "quite usual". She commented that while forensic services would, as required, facilitate contact with lawyers, and connect patients without representation with lawyers through the Public Trust and the Family Court, many people who enter the system through the criminal justice gateway will already have a lawyer.

[382] Similarly, when Dr Barry-Walsh was asked whether an international report which suggested that mental health patients tend not to be well-represented because they are unable to obtain legal aid accorded with his experience, he said:

> It's not my experience particularly in relation to Mental Health Act matters. I don't ever recall being involved in an application for a compulsory treatment order where the patient didn't have legal representation and if they didn't I would have been concerned and would have contacted the District Inspector and others to see whether we could facilitate that. So that hasn't been my experience.

[383] Again, the only specific issue raised and pursued concerning access to legal advice related to Mr S. Dr Judson gave a detailed explanation about his relationship with lawyers from a clinical perspective:

> … he wants to call his lawyer every five minutes and it's not about legal matters, it's just that the lawyer is somebody who's kind of an important person he needs to contact. Whenever there's been any kind of legal process or any kind of hearing or any kind of review, [Mr S] got over anxious, over excited, he starts to see all sorts of likely outcomes … from getting lots of money to getting moved to some other place to getting people sacked, to getting a new person here or a better lawyer here or whatever it might be and things really spiral out and it's something that we've seen a lot of over the years that whenever there's been any kind of legal involvement going on or legal expectations Mr S gets overly excited and his anxiety and often his, raises in his behaviour can really get out of hand.

[384] Dr Judson's evidence on this topic provides a further example of why it was sometimes clinically necessary to restrict Mr S's phone calls. He spoke about the challenges involved in getting Mr S to moderate his expectations about the legal process and to focus on what realistic outcomes might be, and in discouraging him from

> … ringing three different lawyers or trying to get all these people involved all the time … so that if there is a process going on, make sure that he has one lawyer who comes and understands him and can sit and talk to him realistically and make sure that if there are things that have been talked about,

> if possible they try and then make sure that his supporting staff are aware of what those things are so they can help him to process it … his lawyer for many years who was dealing with some of the mental health things got to know him very well. [Mr S] would want to ring him every five minutes and so he had to put some limits and say, look I can talk to [Mr S] at these times about these things but he can't ring me all the time you know, okay he's got a legal right to ring but it's not good for him. …So … it's always difficult … because … obviously a patient has a right to legal advocacy but for somebody like [Mr S] if … he's talking to too many people, getting slightly different messages or getting information that raises his expectations, … then he becomes more anxious so we try to, we've tried to limit that as much as is possible within also giving him sufficient access to advocates and lawyers to be fair and proper. So it's a difficult balance that one and we've tried to get it right but it's not always been easy.

[385] The reference by Dr Judson to one of Mr S's lawyers asking that limits be put on Mr S's phone calls is reflected in the documentary record. But the record also shows that the lawyer concerned (Mr Bott) asked on other occasions that Mr S should be permitted to continue to contact him, even when phone calls to others were restricted. Apart from one instance involving a delay of a few hours, there is no evidence of any difficulties in that respect.

Leave

[386] Dr Skipworth and Mr Fairley gave evidence about leave policies at the Pōhutukawa Unit and the Haumietiketike Unit. In essence:

(a) a forensic patient's legal status will determine what leave they are potentially entitled to, and who is involved in considering and approving a leave request;

(b) leave from hospital (under MHCAT Act) is a matter for the Director of Mental Health (if the person is a special patient found unfit to stand trial) or the responsible clinician (if the person is a civil inpatient); and

(c) leave for those subject to the IDCCR Act is governed by that Act and, generally speaking, is administered by the care recipient's care co-ordinator and care manager. Leave for special care recipients is approved by the Director-General of Health or their delegate.

[387] So approval from the relevant authorities must be gained before leave can be taken. But leave approval does not automatically lead to leave. Clinical/risk concerns will always override approved leave. The responsible clinician and key worker are accountable for ensuring it is appropriate for the leave to proceed. Whether it is appropriate for leave to proceed must always be assessed within the hour prior to any leave being taken.

[388] Travel precautions are determined by the needs of the patient at the time of the event. Generally, patients do not travel with other patients and leave is granted on an individual basis. Staff generally will escort patients on leave, at times with an increased staff to patient ratio.

[389] It is, accordingly, self evident that the pleading that the applicants were not permitted to leave hospital without authorisation and/or supervision is true. But the requirement for authorisation and supervision is a matter of law and a necessary function of their detention under the relevant legislation. It cannot possibly found a claim that s 23(5) has been breached.

[390] As developed at trial, however, it seems that the claims about the denial or withdrawal of leave related particularly to Mr M. More specifically, it was said that staff have used such denial or withdrawal as a form of punishment, to force him to comply with staff directions. There is also once such allegation relating to Mr S.

Mr M

[391] The evidence made it clear that Mr M, more so than Mr S and Mr C, was often actively unhappy at his continued detention in the Units. In part, his unhappiness was because (as Dr Duff explained it) for Mr M the "grass was always greener" somewhere else and so he spent considerable time and effort attempting to be transferred from one Unit to another and then back again. As well, however, it seems clear that the various ways in which Mr M tended to manifest his unhappiness resulted in further restrictions being placed on him, thereby exacerbating the cause of his distress. In his DVD interview, Mr M referred to these as "hard times".

[392] One notable example of this "vicious circle" in action can be seen from the numerous times on which Mr M absconded whilst on leave (or went "AWOL"). Dr Duff gave evidence about this, including occasions in March 2004, November 2004, May 2005, August 2007, March 2010 and May 2011. One such incident involved Mr M managing to travel from Wellington to Auckland; he was AWOL for a number of days. He eventually telephoned staff at Pūrehurehu from Auckland, saying that he wanted to find a place at the Mason Clinic.

[393] This tendency to abscond while on leave caused a number of difficulties for clinical staff. First, and most obviously, is the point that Mr M was, by law, required to be detained and the DHB was legally responsible for ensuring that that occurred. Absconding was regarded as a serious matter and required review of his safety risk and his management plans, to ensure that they were still appropriate and would achieve that end. Secondly, although the withdrawal of leave (and thus the principal opportunity to abscond) was the logical response to AWOL incidents, it necessarily had a further negative effect on Mr S, and his resulting assaultive behaviour would further diminish prospects of getting what he wanted (namely leave and, ultimately, release into the community). As Dr Duff said

> … his behaviours often made it very difficult to justify the granting of leave and there was continual striving to create a window of opportunity in which his behaviour could be considered safe enough to be able to get the reinforcing progression back in place again but his behaviour was often so difficult, it was very difficult to justify too because we have to balance the safety of the staff and the public against his needs as well so when somebody is, you're violently assaulting staff, it's very difficult to then say, great let's go out … and particularly with his history of having committed a very serious offence the day following a discharge from a forensic mental health unit which is, so it's complicated but that was always the aim was to try to get windows of opportunity where you could put in some reinforcement for positive behaviours however short the positive behaviours had been for, to reinforce them.

[394] Dr Duff explained that when Mr M's leave was cancelled, it was reinstated as soon as safe to do so, but that he presented some unique challenges in that respect. She said:

> It's [a] very basic sequence of events that needs to occur and it was very difficult to get [a] sufficient period where Mr M was showing safety, wise mind behaviours, engagement with the plan, even where the plan was fairly resolutely positive. So as soon as was practicable, as soon as the incidents

> calmed enough, we were straight back on to a leave programme for Mr M, back into Spark studios, back out on visits again, rapidly as we can but it's very difficult to achieve that when he is randomly punching chaplains on the back of the head and it's incredibly difficult then to justify taking him out to a public place and exposing the public to those risks.

[395] When it was put to Dr Duff that Mr M's leave was cancelled as a form of punishment and control she said:

> … I wouldn't agree with that, …we are tasked with the secure service, with the safety and protection of the public, of the individuals in our care and to justify that leave means that it has to be done in the context of a risk assessment and it's not about us wanting to "win" against [Mr M], we constantly fought not be in a head-to-head battle with [Mr M] because actually we always lost in a head-to-head battle with [Mr M] and we wanted to always be round the same side as [Mr M] saying, these are the barriers to us getting out, to what you're wanting to achieve, how can we work on them together; so there's a lot of involvement … all the way through by the services to try to get him to be on the same side as us and not to have him then adopting a fighting stance which makes it then so difficult to achieve the things that he says he wants to achieve.

[396] Similarly, she said:

> That was a … continuous effort on our part to try to adapt to the clearly additional messages that [Mr M] gave the system continuously but because this was his chronically entrenched way of responding to the world … we were continually affording opportunities to try and work it through, and over the years, you know, the amount of time in which he … became angry, became better, so there was progress against those things. He was more prepared to talk it through with us, … would write letters to us, telling us we'd done a good job and telling us we'd done a bad job, and so he got better at finding more functional ways of expressing his unhappiness with what was happening around him which ultimately we would very much hope will result in him not then resorting to offending behaviour in the future when he faces some other sorts of challenges.

[397] Again, the fact that Mr M eventually transitioned into community care notwithstanding the challenges just outlined seems to me to be a testament to the perseverance both of Dr Duff and her staff and to Mr M himself.

Mr S

[398] There was one occasion referred to in evidence on which Mr S's lunch date was cancelled following dysregulated behaviour. It was put to Dr Barry-Walsh that this was an example of using the withdrawal of leave as a punishment. But Dr Barry-

Walsh denied that. He said: "… it's a response to his mental state. It just made it too risky to do that". I accept that evidence.

Conclusions

[399] Based on the evidence I have outlined above I am of the view that:

(a) there has been no failure to provide the applicants with appropriate rehabilitative and therapeutic activities, let alone a failure that might constitute a breach of 23(5);

(b) there has been a concerted and dedicated effort to help the applicants move out of secure compulsory care and into community care. That effort has recently been successful in the case of Mr M and partly successful in relation to Mr S;

(c) there has been no denial of visits, telephone calls, correspondence or contact with advocates or lawyers, except temporarily, where clinically justified;

(d) the decisions to cancel leave following Mr M's AWOLs were not in breach of s 25(3) or made to punish him. Rather they were rational and necessary responses to the risk he posed and to the WDHB's legal obligations; and

(e) the cancellation of Mr S's lunch date was not used as a form of punishment.

FIFTH CAUSE OF ACTION – SEXUAL RELATIONSHIPS

[400] The fifth cause of action pleads that:

(a) the applicants have 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 contact involving patients; and

(c) the applicants' private sexual activities have been unlawfully interfered with.

[401] It is said that ss 9 and 23(5) of the NZBORA incorporate a right to family life, and that the applicants' autonomy and dignity requires sexual relationships to be facilitated by the respondents.

The evidence

Sex

[402] Ms Daysh confirmed that while, in mainstream disability services, many patients have sex, are married or have children, that was not the position in medium secure forensic services. All of the respondents' witnesses who gave evidence about the issue confirmed that sexual activity between patients in forensic (intellectual disability) units was prohibited. Indeed, the evidence was that staff attempt to prevent any opportunity for such activity by keeping patients under observation. All witnesses were united on the reasons for this policy. By way of summary:

(a) often there will be patients in the Units who have, themselves:

(i) been involved in sexual offending; or

(ii) been victims of sexual offending;

(b) by virtue both of their disability and (often) their own history of sexual abuse many patients:

(i) have difficulties with appropriate sexual expression;

(ii) are unable fully to understand or deal with issues of consent;

(c) there is a high risk of power imbalances and exploitative behaviour in any sexual relationship the patients might have;

(d) where both parties to an intimate relationship are compulsorily detained in the same small Unit, each is unable to remove him or herself from proximity to the other in the event that the relationship strikes difficulties or comes to an end; and

(e) permitting intimate personal relationships between patients would likely have a deleterious effect on others in the Unit and the overall dynamics within it.

[403] Where sexual activity does nonetheless occur, the matter is treated as an "incident", and reporting processes are engaged.[145] At WDHB there is a specific policy regarding sexual assault. At CCDHB a sexual assault would be dealt with using the policy which applies to other incidents on the unit. Sexual health checks would be carried out as necessary and appropriate following such an incident.

[404] In response to a question about whether permitting sexual activity might (if it could be properly controlled or supervised) have potential therapeutic and rehabilitative benefits, Dr Judson said:

> I doubt it, to be honest. I mean, in the context of a secure unit where you may have some people who have sexual predators with perhaps very limited understanding of consent and other people's boundaries, if they are aware that people are having sex within the unit then they could – it's likely that they will have difficulty in understanding the rules about their own sexual behaviour, for example. I think when you've got that kind of complex dynamic of predators, victims, and all of the other kind of mix of relationships in a small, closed unit then adding that sort of potential sexual dynamic is – it's potentially very damaging. I'm not sure how that would improve anybody's mental health, to be honest. …

[405] And during Ms Medlicott's evidence there was the following exchange:

> Q. And the penultimate paragraph on that page, "Any sexual activity in this setting can be damaging for all concerned, whether or not it's perceived to be consensual," is it –

[145] A specific instance of this has been dealt with under the first, third and thirteenth causes of action.

A. Yes.

Q. – is there a possibility that it could also be therapeutic?

A. Not in my experience, no not at all.

[406] In terms of intimate touching falling short of intercourse, Dr Duff confirmed that patients are able to hug and kiss their relatives but are discouraged from such activity with other patients in the Unit. She explained:

> …these are general rules and they arise from practical reasons, so one person's play punch is another person's assault for example. We talked about there being a lot of sexual offenders within the unit so touching is potentially sexualised as well but within the service we have a visiting hairdresser, for example, who comes every six weeks, we have a podiatrist who comes, so there's a variety of other people who will casually have physical contact for other reasons with the individuals. But as I say, as a general rule we are discouraging them from having physical contact with one another on the unit for, because they have a right to expect that other people will not touch them as well. For any one individual they may thoroughly dislike being touched by another care recipient and as you say these are not flatmates where they can choose to take themselves off somewhere else, go live in a different place with different people. These are people who are in compulsory care and so the no touching rule as a general rule I feel is a reasonable rule to have.

[407] Dr Duff was asked about whether the absence of touch could contribute to recognised psychiatric disorders. She said that an important distinction had to be made between developmental problems which may be caused by an absence of physical contact as children or complete sensory deprivation and "adult men going through a period of their life where they are only having handshake contact physically". She acknowledged that it was possible, in theory, for a lack of touching to contribute to depression but explained the steps taken to try and prevent this from happening. Reference was made to other physical supports which are available for patients such as SPCA petting zoo visits, the use of the sensory room and weighted toy pets and blankets. The weighted toy pets and blankets could be seen (and felt) during the Court's visit to the Units. Mr C's use of a weighted toy cat to soothe and support him during his DVD interview was readily apparent.

[408] Ms Medlicott's expert view was that the policy of no kissing, hugging or touching was clinically appropriate.

[409] Another key theme of Mr Ellis' cross examination on this issue was why patients in forensic ID units should not be able to have access sex workers. In that respect, Dr Judson said:

> ... Use of sex workers would be incredibly problematic. I know this has often been mooted by various advocates and people who want to be helpful but I think in general that's a very, very destructive thing, partially because the understanding of the rules of sexual engagement and consent issues and gender roles and all of those kind of issues can be very, very blurred when you're using a sex worker. For example, [if] somebody …was permitted access to a sex worker, we would have to be very sure that they had a very clear understanding of the difference between sexual engagement with a sex worker and relationship[s] between [them and] other females, female staff, female visitors, or whatever. Now, many people would have a lot of difficulty in that kind of understanding and the risk would be that you would then introduce that element of people assuming that females were then sexually available, and then you've got the risk of the kind of increase of assaults. So, you know, it's something that you never say absolutely never but it's got to be in – it would only be in very, very, very carefully considered individual circumstances.

[410] Similarly, when Dr Duff was asked why patients could not have sex with sex workers, she said:

> So that – none of these issues haven't been discussed at some length within the, while setting up the service and during the tenancy of the service. So again the use of sex workers has been used in people who are living in community settings, and there have been some issues and difficulties encountered in the safe management for the sex worker, and also safety for the care recipient as well. So there's issues around supervision, there's issue[s] around safety for the sex worker, there's issues around whether the sex worker then exploits or doesn't exploit the care recipient within the service. So we have thought about the issues in relation to that. I know that at times people have had supported access to sex workers at lower levels of compulsory care than the hospital level of care. But we saw no reasonable way in which that could be facilitated and the dignity and privacy and safety aspects of a transaction with the sex worker be appropriately supervised by staff.
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> …
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> The reason why I say that is one of the specific examples that I know occurred for – not for one of these gentlemen but someone who was at a supervised level of care and therefore the supervising staff didn't need to be in the room and obviously didn't want to be in the room in terms of invasion of privacy but it later emerged from the care recipient that he was not receiving the services that he had paid for from the sex worker who had told him that this was the normal transaction for this amount of money [and] by virtue of his intellectual disability he had believed that. So he had had trouble understanding the contract and the terms of the contract and what he would get for his payment from the sex worker and because there was no supervising person there nobody was aware of the fact that that was occurring for some

> period of time so there's potential difficulties even not allowing for the additional complexities of a medium secure level service.

[411] When it was put to her that this approach was discriminatory, Dr Duff responded:

> I don't believe that we are discriminating specifically against intellectually disabled people. As far as I'm aware, people at medium secure level of care of mental health are not supported to see sex workers whilst they're still under compulsory orders. There's also our duty of care. There's also a number of other factors relevant within the situation. I think it's more an issue of the weighing up of the safety and whether we can safely support that rather than an inherently discriminatory situation.

[412] And when he was asked why Mr S could not have a sex worker visit him in his room, Dr Barry-Walsh said:

> Well, I think there's a number of problems with that. The first one is what would have been the risks to [Mr S] and to the sex worker if that occurred? I think there would have been legitimate concerns for how he would have understood the relationship. There would have been legitimate concerns about how that may have impacted on his anxiety and his capacity for becoming violent. Then from a service perspective, that would have been without precedent. I don't know what the view of the district health board would have been to a sex worker visiting him in the privacy of his room. I'm not sure of what the legal implications of that would be. Then there would be the concerns about the capacity for him to be exploited by a sex worker, as well.

[413] Even the applicants' expert, Dr Webb, agreed that it would not be sensible to have sex workers visiting Haumietiketike and Pōhutukawa, at least as the Units are currently configured.

[414] Ms Medlicott gave evidence about policies about sex adopted by forensic units in comparable European jurisdictions. She said: "I believe that we are fairly equivalent to the majority of the countries in Europe within New Zealand in our practices and our inpatient facilities". She also referred to and endorsed the Victorian Chief Psychiatrist's guideline for managing sexual safety and responding to allegations of sexual assault in acute adult inpatient units. That guideline says "sexual activity in a treatment setting is not appropriate and should be actively discouraged". Her view did not change after reading various articles about contrary overseas policies that had been put to her by Mr Ellis.

Absence of written policies

[415] While the prohibition on sexual activity within the Units is very clear, it has never been committed to writing. While attempts have been made to draft a written policy on sexual activity and sexual expression within forensic (intellectual disability) services, that has not yet come to fruition.

[416] Dr Judson was asked whether it was "fair" that there was not a written policy for patients on this issue. He agreed it might be helpful for staff but did not agree that it would be particularly helpful for most of the patients, as they would not be able to read it. But he confirmed that patients are told explicitly that sexual activity is not permitted.

Sex and relationship education

[417] The provision of sex and relationship education was explored with several witnesses who indicated that such programmes were offered by the two DHBs and in the Units when considered clinically necessary. Wider education about relationships and appropriate physical interactions are also available.

[418] Dr Barry-Walsh explained:

> Sex education happens a lot as part of people's individual treatment programmes. So you see some people attend sex offender treatment programmes.
>
> […]
>
> That isn't necessarily around sex education. However, quite often in a lot of reports that you see coming up under section 23 and 35 and in a lot of behaviour support reports, you'll see comments written around sexual knowledge testing, and so a lot of those reports come before the Court. And where people are found to be deficient in terms of their sexual knowledge, quite often education programmes will be put around that. That's not necessarily by a psychologist. Sometimes they are supported to attend family planning or sometimes even their own GP. Sometimes that's around talking about matters around contraception, but sometimes those conversations are around the nature of sexual relationships, and there are a number of psychologists working in the disability field who will work specifically with individual patients, for example Tania Breen. One of the large areas of her practice is working with people with intellectual disabilities, around sexual knowledge.

[419] In response to a question about what help is given patients to understand issues around consent, Dr Judson said:

> All of our patients engage in a range of psychological therapies and one of those would be looking at issues of sexual activities, consents, relationships. Quite a lot of the people that we have, particularly those who have problems with sexual offending, have particular – have specific therapy from an organisation called WellStop which provides sexual – which provides counselling and therapy for those people who have sexual[ly] offend[ed] but all of the patients within our services would go to groups and psychological therapies and Mr Oxnam will be able to tell you more about these where things like relationships are looked at and some of that will be individual. Some of it may be as a group, and it will also depend on the individual's understanding and the individual's needs.

[420] He said:

> … we do, we have sexual relationship discussions, we talk about safe sex, they have used condoms in part of our sex education programmes, so they have learnt the mechanics of how to put on a condom. So we don't ignore the issue but within the secure services we say it's not safe.

[421] And Mr Oxnam's evidence was that, as part of his Stepping Stones programme:

> … we talk about things like boundaries, what makes for a good relationship, how to form friendships, how to deal with peer pressure and peer influence. Those are the main – healthy relationships rather than – and also I guess the fact that it's okay for somebody to have, that any kind of sexual preference or sexuality type is fine for the patient, so normalising their experiences to prepare them for living in a less secure environment.
>
> […]
>
> In our social skills module we teach patients about proximity and boundaries, who it's okay to hug, who it's not okay to hug, the difference between a relationship, the relationship you might have with a staff member versus your family versus other patients. We use a, several circles to graduate out the types of things that are okay with these different groups. We teach a concept called the bubble and essentially we say the bubble starts here and move around like that and you try not to come inside somebody's bubble.

Condoms

[422] The applicants say that condoms should be provided "proactively" to patients in the Units.

[423] There is no record of a request for condoms ever having been made by any of the applicants. But the evidence was that condoms are not routinely made available,

because making them so would be inconsistent with the policy preventing intimate relationships.

[424] A comparison with prisons (where condoms are provided to inmates) was put to Dr Duff. She said:

> A very different setting in prisons, though, Mr Ellis, than in our unit. Our unit is a very small unit with high levels of staffing, high levels of supervision and support. Much more so than where double-bunking occurs in prisons and there's an expectation of a lack of supervision between prisoners for periods of time, with no communal showering areas. We have rules which you disagree with but which we have about not inviting peers into the privacy of their bedrooms, for just those purposes: to protect the individuals from the potential for abuse. We do the utmost that we can. We feel it would be an incredibly mixed message to be saying, "Actually but you're not very safe, so here's a condom in case somebody does decide to come into your room," so we don't provide the condoms.

[425] Ms Daysh's evidence was that the position was the same in Haumietiketike:

> A forensic service where there is an understanding that patients do not engage in sexual acts with one another, it is very unlikely for condoms to be provided. In community services patients are supported to go to Family Planning and to their GPs and certainly some of them will purchase condoms with their groceries but that is not the case in forensic services.

[426] Ms Daysh also confirmed that condoms were not provided inside the Unit because to do so would send confusing mixed messages.

[427] Lastly, when it was put to Ms Medlicott that it would be a good idea to provide condoms and contraceptives as some European countries do, despite the inherent contradictory messages that might send, she said:

> I don't agree that it would be sensible. I think we have a lot of women in particular who are on long-term contraceptive devices, medication and so on. The issues around sexually transmitted diseases is more difficult. It would seem to send a very mixed message to say it's not safe for you to have sex on this unit for a variety of reasons but, hey, if you do here's a condom. We know that when people go into the community some people are on six days a week in the community, one day back in the unit, for example, that they may well be accessing condoms and having positive sexual interactions in those environments and that's fine, but within the inpatient setting it's certainly a complex area.

Masturbation

[428] There was no evidence that masturbation is prohibited or discouraged in the Units. Rather, the evidence was that the DHBs recognise that their patients have sexual needs and that masturbation is a normal part of sexual expression. They do not seek to prohibit masturbation in private. But patients masturbating in a public area are directed to their own rooms.

[429] That said, however, as the facts underlying the first, third and thirteenth causes of action demonstrate, staff need to be observant of patients in the Units in order to keep them safe. The evidence was that observation is required by various protocols, and is as unobtrusive as possible. It is a matter of clinical judgment as to what level of observation a patient requires, depending on the acuity and level of risk posed by him or her. Clinical staff understand that patients need time by themselves and that is permitted where clinically safe to do so. But, ultimately, the level of observation of a client may be high in order to manage that patient's presentation and risks.

[430] Consistent with the position just described, the evidence showed that clinical file notes may record masturbation when it is observed. This occurs where masturbation relates to risk behaviours, indicates changes in mental state, occurs in an inappropriate place, appears to be deviant in nature, or compromises the care or safety of other residents or staff. But where the file notes did contain such records, it was usually of a general nature rather than detailing the acts involved. Equally, masturbation is not recorded where there are no specific risk concerns.

Pornography

[431] The documentary record shows that, on 21 December 2008, pornography was confiscated from Mr S's room at Haumietiketike. The notes record that he was largely settled in mood over the following days but on 5 January 2009 he seriously assaulted a staff member, and was consequently restrained and secluded. He was then managed in de-escalation. He spoke to Dr Duncan on 8 January 2009 and said he could not see why he could not have the images returned. The multi-disciplinary team considered the images on 27 January 2009, and determined that they should not be returned to Mr S.

[432] The gist of Mr Ellis' questions in relation to this issue appeared to be whether the material was actually pornographic. But it seems that the images in question have since been removed and destroyed from Mr S's file. The only available descriptions of that material as recorded in contemporaneous documents are:

(a) "Pornographic images";

(b) "Five graphic images"; and

(c) "Explicit pornographic male orientated material".

[433] More generally, Ms Daysh's evidence was that pornography was not banned in Haumietiketike. Indeed, she said, access to pornographic material can form part of a plan to facilitate access to appropriate materials for masturbation with patients detained following sexual offences. However, Mr Fairley said that violent or sexual material classified as R18 was not routinely available to patients, in order to maintain a safe environment in light of the mix of patients with complex offending and/or abuse histories. There was also evidence of concerns that normalising sexual behaviour on the Units can lead to patients seeing staff as sexually available.

Discussion

Sex

[434] The respondents that say it is untenable to suggest that preventing intimate relationships in the circumstances of the applicants' detention amounts to torture or cruel, degrading or disproportionately severe treatment in breach of s 9. I agree, and do not discuss that contention further.

[435] As far as s 23(5) is concerned , the proposition that humanity and dignity require that patients such as the applicants be permitted to form intimate relationships runs counter to what clearly *is* the respondents' duty under that section, namely to take reasonable steps to ensure that patients are safely detained. As I have said, the evidence was overwhelming that patients' well-being is the driving force behind the

"no sex" policy. And it is also because of that obligation (which is expressly reflected in s 11 of the IDCCR Act) that no specific power to prohibit sexual activity is required.

[436] Although Mr Ellis suggested sexual relationships might have a therapeutic value, this was not accepted by witnesses to whom he put that proposition. Rather, their evidence was overwhelmingly to the effect that permitting such relationships would be highly likely to risk patients' well-being and would impede, rather than facilitate, their rehabilitation.

[437] I therefore consider that there is no inconsistency between the prohibition on sexual activity and the DHBs' obligations under s 23(5).

Absence of written policies

[438] As the respondents submitted, the only difference between an established and well understood practice and a written policy relates to the question of accessibility which, in turn, can affect whether a limit on a right can be regarded as being "prescribed by law" under s 5 of the NZBORA.

[439] The important point is that the evidence demonstrates that the policy is soundly based, well-understood and consistently applied. Although a written policy might be desirable there is no legal obligation to have one.

Sexual and relationship education

[440] The respondents deny that the rehabilitative purposes of the MHCAT Act and the IDCCR Act impose any duty upon them to provide sexual and relationship education and say that such a duty would impermissibly strain the boundaries of s 23(5).

[441] While I am prepared to accept that as a general proposition, it seems to me that the position may be different if a patient has a specific rehabilitative need in that area. If, for example, a patient is regarded as posing a risk of sexual offending which must be addressed in order for him to be released from compulsory treatment then there must at least arguably be a rehabilitative duty (and a s 23(5) duty) to do so.

[442] But there is no evidence that that is the case in relation to any of the applicants except, perhaps, Mr M who has in fact now been released from compulsory care. That necessarily implies that any issues he had in that regard have been dealt with. But in any event, the evidence more generally shows that sexual education and relationship education has, in fact, been a part of all the applicants' rehabilitation and treatment. This aspect of the claim must also fail on the evidence.

Condoms

[443] The two ways in which the "no condoms" policy could be inconsistent with s 23(5) are:

(a) if the ability to use condoms is required in order for the applicants to be detained with humanity and dignity; or

(b) if failure to provide condoms gives rise to a risk to detainees' health that is inconsistent with s 23(5).[146]

[444] In terms of the former, it cannot be right that the provision of condoms is a prerequisite to the applicants' humane detention. As the English High Court has confirmed in a case involving a secure mental health facility, the "no condoms" policy is a rational extension of the "no sex" policy which, as I have already found, does not itself breach s 23(5).[147]

[445] As regards the latter point, there was no evidence that patients' health and safety are more at risk because of the no condom policy. While distributing condoms might decrease the risk of sexually transmitted infections, that risk is already low by virtue of the no sex policy. By contrast, sending a "mixed message" to patients might lead to an increase in the number of sexual encounters overall and thereby increase the risk of STIs, particularly where it is far from clear that the condoms would actually be used.

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146 The respondents accept that s 23(5) includes a positive duty to protect detainees' physical integrity, independent of any right to private and family life (which the respondents say does not exist in New Zealand law).

147 *R (RH) v Ashworth Hospital Authority* [2001] EWHC 872 (Admin).

[446] I note that in the English case just mentioned, the Court found there was no real and immediate risk of harm to either life or health flowing from the hospital's refusal to provide condoms, because of the no sex policy, the low likelihood of sex occurring despite the policy, and the general absence of sexually transmissible diseases among detainees.[148] Accordingly it was held that there was no duty to provide condoms in terms of either the right to life (art 2 ECHR) or the right to a private and family life (art 8).[149]

[447] Similarly, in the present case, there was simply no evidence of any real and immediate risk.

Masturbation

[448] The respondents accept that facilitation of reasonable privacy in order that detainees may perform intimate personal activities is an obligation that falls within s 23(5). They acknowledge that it is arguable that humane treatment requires that long-term detainees be given sufficient privacy to engage in masturbation. But, as they also emphasise, masturbation per se is not protected by s 23(5); the interest protected is better described as a reasonable degree of personal privacy, so far as the purposes of detention, and the safety of all those detained, permits.

[449] The evidence here was that masturbation is only stopped by the respondents when it occurs in public areas. There is no prohibition on masturbating in private. Limitations on masturbating in a shared space are not, in my view, capable of constituting a breach s 23(5). Rather, those limits are plainly necessary for maintaining an appropriate therapeutic environment for all patients.

[450] And while there are records of the applicants masturbating at various times, that does 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 the legitimate clinical purposes to which I have referred above. And in any event I agree with the respondents that it is simply not possible

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148 Although the applicant himself was a carrier of Hepatitis C. In total, 16 out of 400 patients had either Hepatitits B or C, and none had HIV.

149 Article 8 was found to include the right to protection of physical integrity.

retrospectively to interrogate the reason for each record of masturbation. And nor did Mr Ellis attempt to do so.

[451] Again, this aspect of the claim must fail on the evidence.

Pornography

[452] The allegation is that the removal of the pornographic images from Mr S's room breached of his freedom of expression under s 14 of the NZBORA, although there are some deficiencies in the pleading in that respect. Mr Ellis also appeared to contend that this seizure was illustrative more generally of the interference with the applicants' ability to explore their sexuality and engage in private sexual activities, in breach of ss 9 and 23(5).

[453] The applicants rely on *Hudson v Attorney-General* as authority for the proposition that detainees have a right to pornography.[150] But in my view that case is of little assistance here; it says nothing about ss 23(5) or 14; the Court refused to engage with NZBORA arguments. Rather, it simply held that destroying a prisoner's confiscated pornography was in breach of s 45 of the Corrections Act 2004, a procedural provision governing the disposal of prisoners' property.

[454] For myself, I cannot see how s 23(5) is engaged by the removal of inessential possessions from detainees. To the extent pornography is linked to an asserted "right" to masturbate, it cannot found a claim for the reasons I have already given. Put simply, if a rights-based analysis is to be utilised in this area the appropriate focus is on privacy, not the act itself.

[455] And even if s 14 is engaged here, it is trite that pornography is a low value form of speech, interference with which will be relatively easily justified under s 5. As Lady Hale said in *Miss Behavin' v Belfast City Council*:[151]

> … there are far more important human rights in this world than the right to sell pornographic literature and images in the backstreets of Belfast city centre. Pornography comes well below celebrity gossip in the hierarchy of speech which deserves the protection of the law.

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150 *Hudson v Attorney-General* HC Wellington CIV-2010-485-773, 17 December 2010.
151 *Miss Behavin' Ltd v Belfast City Council* [2007] UKHL 19, [2007] 3 All ER 1007 at [38].

[456] And in terms of justified limits, the evidence here was that the removal of pornography from Mr S's room involved the balancing of his interests against the interests of other patients (many of whom have either committed sexual offences or been the victim of sexual abuse) and against the interests of staff. Removal of pornography from the Unit is therefore an important and well-reasoned part of patient well-being and rehabilitation, and a justifiable limit on any individual patient's s 14 rights.

Conclusions

[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;

(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.

SIXTH CAUSE OF ACTION – USE OF SECLUSION AND RESTRAINT

Preliminary comment

[458] This part of the sixth cause of action is strangely pleaded. The principal pleading is essentially that the unnecessary and inappropriate use of restraint and seclusion (which the pleading refers to as "solitary confinement") following the conclusion of the applicants' "punitive periods of detention" constitutes an arbitrary detention in breach of s 22 of the NZBORA.

[459] I record at the outset that I agree with the respondents' submission that this pleading is misconceived. First, it is predicated on the notion that a special patient order or a special care recipient order resulting from a finding of unfitness to stand trial constitutes a "punishment". It is not. That is confirmed by the case-law.[152] And it is also why Mr Ellis' reliance on *Belcher v Chief Executive, Department of Corrections* is misplaced.[153] The Court of Appeal in that case held that the Extended Supervision Order regime under the Parole Act 2002 was punitive notwithstanding its risk mitigation purpose.[154] But while risk mitigation also underlies the alternative disposition options under the CPMIP Act, it is quite clear that:

(a) those options are not predicated on a criminal conviction; and

(b) rehabilitation and treatment (rather than punishment) is the overarching goal.

[460] Secondly, I am inclined to agree with the respondents that the use of seclusion alters the conditions of detention rather than affecting the lawfulness of the detention itself: *Bennett v Superintendent Rimutaka Prison.*[155] Although Mr Ellis relied on (the

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152 See for example *Winko v Forensic Psychiatric Institute* [1999] 2 SCR 625, discussed in more detail later in this judgment.

153 *Belcher v Chief Executive of the Department of Corrections* [2007] 1 NZLR 507.

154 At [49].

155 *Bennett v Superintendent Rimutaka Prison* [2002] 1 NZLR 616 (CA) at [62] (in relation to s 23(1) of the Bill of Rights Act). Butler and Butler suggest the principles apply equally to s 22: Andrew

very much obiter) dicta of the Court of Appeal in *R v Briggs* which appeared to doubt that the dicta from *Bennett* could be directly applied in a s 22 case, it seems clear that the Court was concerned there with the lawfulness of the arrest on new charges of persons already detained, rather than a "detention within a detention" (which was the focus of *Bennett*).[156] All the Court said was that "s 22 protects human dignity and autonomy as well as liberty, and those interests are not wholly lost on incarceration."[157] That serves to underscore the respondents' point that s 23(5) (and in truly egregious circumstances, s 9) is the appropriate focus here. I do not intend to consider s 22 further in the context of the sixth cause of action.

[461] On that basis, the applicants' main contentions about the use of seclusion and restraint seem to me to be as follows:

(a) the use of seclusion and restraint (including "night safety procedures") amounted to a "solitary confinement regime" in breach of ss 9 and 23(5) NZBORA. More specifically, this aspect of the claim alleges the use of seclusion and restraint:

(i) as a tool for punishment and control;

(ii) for unnecessarily long periods;

(iii) without appropriate medical supervision; and

(iv) in such a way that amounted to assault and battery;

(b) there was no detailed policy governing the use of seclusion and restraint, and a failure regularly to review such a policy, such that in totality the use of seclusion and restraint amounted to ill treatment; and

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Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015) at 19.6.14.

156 *R v Briggs* [2009] NZCA 244.

157 At [85].

(c) relatedly, in the course of the hearing, the applicants amended their statement of claim to allege specific illegality arising by virtue of:

(i) the (admitted) absence of guidelines relating to seclusion under s 148 of the IDCCR Act;

(ii) the promulgation of guidelines by the Director of Mental Health under s 130 of the MHCAT Act when either:

- the promulgation power (which is conferred on the Director-General of Health) has not been formally delegated; and/or

- any delegation of that power would (in any event) be unlawful);

(iii) failure to review HDSS Act standards in accordance with the requirements of s 24 of that Act.

[462] The discussion and analysis that follows will be structured under the following headings:

(a) the regulation of the use of restraint and seclusion in the context of a forensic unit for those with intellectual disabilities (including legislation, standards, guidelines and policies governing such use);

(b) restraint and seclusion in practice;

(c) night safety orders;

(d) specific instances of the use of restraint and seclusion in relation to the three applicants; and

(e) analysis of the claims.

Regulation of the use of seclusion and restraint in forensic units

Legislation

[463] As to seclusion, the MHCAT Act authorises the placement of patients in seclusion where necessary for their treatment or for the protection of other patients. More specifically, s 71(1) provides that seclusion is a specific exception to the general right to the company of others and subs (2) sets out the prerequisites to the use of seclusion:

> (2) A patient may be placed in seclusion in accordance with the following provisions:
>
> (a) Seclusion shall be used only where, and for as long as, it is necessary for the care or treatment of the patient, or the protection of other patients:
>
> (b) A patient shall be placed in seclusion only in a room or other area that is designated for the purposes by or with the approval of the Director of Area Mental Health Services:
>
> (c) Except as provided in paragraph (d) of this subsection, seclusion shall be used only with the authority of the responsible clinician:
>
> (d) In an emergency, a nurse or other health professional having immediate responsibility for a patient may place the patient in seclusion, but shall forthwith bring the case to the attention of the responsible clinician:
>
> (e) The duration and circumstances of each episode of seclusion shall be recorded in the register kept in accordance with section 129(1)(b).

[464] The IDCCR Act also authorises seclusion, which is defined in s 60(1) as:

> … placing the care recipient without others in a room or other area that—
>
> (a) provides a safe environment for the care recipient throughout the care recipient's stay in the room or area; but
>
> (b) does not allow the care recipient to leave without help.

[465] The section goes on:

> (2) A care manager may place a care recipient in seclusion if it is necessary to prevent the care recipient from doing 1 or both of the following:

(a) endangering the health or safety of the care recipient or of others:

(b) seriously compromising the care and well-being of other persons.

(3) A person who places a care recipient in seclusion—

(a) must ensure that the care recipient is not placed in seclusion for longer than is necessary to achieve the purpose of placing the care recipient in seclusion; and

(b) must comply with guidelines issued under section 148 that are relevant to placing the care recipient in seclusion.

(4) The following provisions must be followed when a care recipient is placed in seclusion:

(a) a care recipient may be placed in seclusion only in a room or other area that is specifically designed for the purpose of seclusion in accordance with guidelines issued under section 148:

(b) in cases other than an emergency, seclusion may be used only with the authority of the care recipient's care manager:

(c) in an emergency, a care recipient may be placed in seclusion by a person who, under a delegation given by the care recipient's care manager, has immediate responsibility for the care recipient, but that person must immediately bring the case to the attention of the care manager:

(d) the duration and circumstances of each episode of seclusion must be recorded in a register kept in accordance with guidelines issued under section 148.

[466] As well, the IDCCR Act specifically authorises the use of restraint. Section 61 provides:

(1) A care manager may restrain a care recipient if that is necessary to prevent the care recipient from doing 1 or more of the following:

(a) endangering the health or safety of the care recipient or of others:

(b) seriously damaging property:

(c) seriously compromising the care and well-being of the care recipient or of other care recipients.

(2) A care recipient may not be restrained under subsection (1) by the application of a mechanical restraint if—

(a) 1 or more authorised individuals can personally restrain the care recipient to achieve the purpose for which the care recipient is to be restrained; and

(b) it is reasonably practicable for those individuals to do so.

(3) The following provisions must be followed when a care recipient is restrained:

(a) a person exercising the power of restraint may not use a greater degree of force, and may not restrain the care recipient for longer, than is required to achieve the purpose for which the care recipient is restrained:

(b) a person exercising the power of restraint must comply with guidelines issued under section 148 that are relevant to the restraint of the care recipient:

(c) in an emergency, a care recipient may be restrained by a person who, under a delegation given by the care recipient's care manager, has immediate responsibility for the care recipient, but that person must immediately bring the case to the attention of the care manager:

(d) the duration and circumstances of each episode of restraint must be recorded in a register kept in accordance with guidelines issued under section 148.

[467] Unlike the IDCCR Act, the MHCAT Act does not deal expressly with, or directly authorise, the use of restraint. But I accept Mr La Hood's submission that restraint is permitted in relation to patients detained under that Act because:

(a) it is implicit in s 71(2) that restraint may be necessary to move a patient into seclusion, for the same purposes provided in s 71(2)(a).

(b) s 122B(2) and (3) authorise the use of force in relation to:

(i) the detention of patients under the Act;

(ii) patients who are required to accept compulsory treatment; and

(c) the use of reasonable force to prevent behaviour that would cause immediate and serious injury to the patient himself or to another person or property is authorised by s 41 and 48–56 of the Crimes Act 1961.

Applicable standards

[468] The use of seclusion and restraint is also governed by Standards, notified and approved by the Minister under the HDSSA. The current Standards were promulgated in 2008,[158] replacing Standards from 2001.[159] Prior to the 2001 Standards there were Ministry of Health guidelines on the use of seclusion and restraint.

[469] The 2008 Standards state that their principal intent is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. They go on to say:[160]

> It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practised, restraint occurs in a safe and respectful manner. Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself, but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices, and training should be firmly grounded in this context.

[470] Restraint is defined in the Standards as "the use of any intervention by a service provider that limits a consumer's normal freedom of movement".[161] Three different kinds or restraint are described:[162]

> Personal restraint: Where a service provider uses their own body to intentionally limit the movement of a consumer. For example, where a consumer is held by a service provider[.]
>
> Physical restraint: Where a service provider uses equipment, devices or furniture that limits the consumer's normal freedom of movement. For example: where a consumer is unable to independently get out of a chair due to: the design of the chair, the use of a belt, or the position of a table or fixed tray[.]

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158 *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* NZS 8134.2:2008 [*2008 Restraint Standards*]. The specific standards for restraint are contained in two further separate documents: *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Restraint Minimisation* NZS 8134.2.1:2008, and *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Safe Restraint Practice* NZS 8134.2.2:2008. And the seclusion standards are in *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Seclusion* NZS 8134.2.3:2008.

159 *Restraint Minimization and Safe Practice* NZS 8141:2001 [*2001 Restraint Standards*].

160 *2008 Restraint Standards*, above n x, at 5.

161 *Health and Disability Services (General) Standard* NZS 8134.0:2008 at 30.

162 At 30.

> Environmental restraint: Where a service provider intentionally restricts a consumer's normal access to their environment. For example, where a consumer's normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as a wheelchair) denied[.]

[471] Seclusion is regarded as a form of environmental restraint.

[472] The 2008 Standards also make it clear that "chemical restraint" is not permitted:[163]

> The term chemical restraint is often used to mean that rather than using physical methods to restrain a consumer at risk of harm to themselves or others, various medicines are used to ensure compliance and to render the person incapable of resistance. Use of medication as a form of 'chemical restraint' is in breach of NZS 8134.2. All medicines should be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only.

Guidelines under the IDCCR Act

[473] In terms of the guidelines referred to in both s 60 and s 61 of the IDCCR Act, s 148 provides that:

> (1) The Director-General of Health may issue—
>
> (a) guidelines for the purposes of this Act; and
>
> (b) standards of care and treatment of care recipients.
>
> (2) The Director-General must ensure that guidelines are issued, under subsection (1), relating to—
>
> (a) the placing of care recipients in seclusion; and
>
> (b) the prescribing of medication for care recipients.

[474] Despite the apparently mandatory terms of s 148(2) no seclusion guidelines have been promulgated under s 148. I return to this later.

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163 *2008 Restraint Standards,* above n 158, at 5. Similarly, the 2001 Standards provided (at 18): "The term chemical restraint is often used to imply that rather than using the above methods to restrain a consumer at risk of harm to their self or others, various medications are used to ensure compliance and to render the person incapable of resistance. Use of medications in this manner as a form of 'chemical restraint' has been a hallmark of abuse and is not supported in this Standard. All medications should be prescribed and used for valid Indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used. This appropriate use should not be construed to equate to 'chemical restraint'."

Ministry of Health Guidelines

[475] The Ministry of Health has published policies which supplement the Standards. In relation to restraint, the Ministry published *Procedural Guidelines for Physical Restraint* in June 1993.

[476] The Ministry has also published the following guidelines in relation to seclusion:[164]

(a) June 1992: *Procedural Guidelines for the Use of Seclusion*;

(b) December 1992: *Procedural Guidelines for the Use of Seclusion*; and

(c) February 2010: *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*.

DHB Policies

[477] Both the CCDHB and the WDHB have their own published policies in relation to restraint and seclusion which are consistent with the national standards. The more recent of these make it clear that the long-term aim is to move towards a "restraint free" service. For example the WDHB's March 2015 policy (*Restraint Minimisation - Adult Mental Health & RFPS*) directs staff to:

(a) treat service users with respect, by listening to their perspectives, validating concerns using polite and thoughtful language offering choice where possible; and informing people of their rights;

(b) understand the potential for restraint to cause loss of dignity, and mana;

(c) apply trauma informed care, understanding that many service users have a history of trauma and this will have a negative effect on their

[164] There are also Ministry of Health guidelines on night safety procedures, to which I refer later, below.

experiences of restraint. The use of tools to reduce the likelihood of restraint is therefore encouraged;

(d) identify and dissolve tensions for people at the earliest identifiable moment; and

(e) involve service users in the development of their own recovery and/or collaborative recovery plans, and sensory preference forms.

[478] The policy also makes it clear that decisions by clinicians to use restraint must:

(a) only be made as a last resort to maintain safety for service users, staff or others; and

(b) follow appropriate planning, using the approved team approach, if the situation allows.

[479] As well, groups within or including the DHBs are charged with oversight of restraint practices and with formulating and implementing consistent policies. These include:

(a) the Restraint Coordination Committee (which is part of the Regional Forensic Psychiatry Service) which meets monthly;

(b) a Restraint Minimisation Group within the Mental Health, Addictions and Disability Service (MHAIDS), which operates across the three lower North Island DHBs (CCDHB, Hutt Valley DHB and Wairarapa DHB);

(c) the CCDHB's Restraint Approval Group, which meets every quarter and whose purpose is to approve restraint techniques and monitor the DHB's compliance with the 2008 Standards.

[480] Unit staff are trained in the use of restraint. The Te Roopu Whakatau programme (formerly known as Calming and Restraint Training) is aimed at

increasing the effectiveness of staff in identifying and preventing challenging and potentially violent situations, and in teaching techniques to try and resolve any behavioural escalation without the need for restraint. The evidence was clear that staff are expected to use restraint only as a last resort and to document the clinical rationale for its use and evidence of alternatives having been considered and (if practicable) tried prior to its use. If restraint is necessary to maintain the safety of patients, staff or others, there is clear policy guidance which outlines the need for intensive assessment and continuous observation of the person who has been subject to a restraint.

[481] So, too, with seclusion. For example the MHAIDS has issued specific policies concerning the use of seclusion.[165] The policy reiterates the CCDHB's commitment to reducing all forms of restraint and seclusion in line with current best practice and emphasises that seclusion:

(a) requires the identification of valid, objective, and clinical reasons for its use;

(b) should be only considered as a last resort after other options for behavioural de-escalation have been considered and tried; and

(c) should be terminated at the first opportunity.

[482] The CCDHB also has a specific policy and procedure on maintaining contact with families when a client is in de-escalation or seclusion.

Seclusion and restraint in practice

[483] Dr Duff's evidence dealt comprehensively with the wider context in which restraint and seclusion occur. What follows is largely based on that evidence, which I unreservedly accept.

[484] The starting point is that for many of the patients detained in forensic intellectual disability facilities, their disabilities and personality disorders make them

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[165] The current seclusion policy was issued on 17 September 2015. Previous policies were issued on 23 December 2010, 18 February 2013 and March 2014.

prone to abusive, aggressive and assaultive behaviour. That is, of course, the principal reason that they have attracted the attention of the criminal justice system and (via that pathway) come to engage with forensic mental health and/or intellectual disability services. There is a range of ways that staff within the forensic units manage and respond to such behaviours.

Prophylactic measures

[485] First, there are individual behaviour management plans which are designed to promote positive behaviour, and, conversely, to decrease the incidence of challenging behaviour. Such plans may be contained within nursing management plans and within risk management plans.

[486] Secondly, where patients are considered to pose a risk to themselves and others, staff use risk management plans to identify and mitigate specific risks. The aim of such plans is to help staff identify known precursors to violent behaviour by the patient concerned and to take graduated de-escalation measures to prevent violence occurring. De-escalation involves talking to the patient, trying to distract him or her from the issue that is causing them distress, encouraging him or her to move to areas of the Unit where the patient will be less dangerous to him or herself and others, and using low-stimulus environments. Dr Duff said that de-escalation occurs regularly and that staff are experienced and skilled at identifying risks and warning signs for each patient and can generally diffuse a situation before a reportable "incident" occurs.

[487] Dr Duff said that a patient who becomes dysregulated to the extent that he or she is considered to pose a safety risk is encouraged to move to the High Care area, which is designed to limit access to things that patients can use to self-harm or to harm others. Moving to High Care is also regarded as useful because:

(a) many patients are more able to calm down when in a low stimulus environment without the presence of other patients. Staff in the Unit are able to work with them one-on-one to help them to relax and re-engage their "wise mind";

(b) it is safest for a dysregulated patient to be away from other patients because displays of aggression and abuse by one patient can have an adverse "domino" effect on others; and

(c) it enables the patient's privacy and dignity to be better protected.

[488] Generally, patients are accompanied to the High Care area and asked to sit down. Staff will then sit with the patient and talk to them until they have calmed down. Dr Duff said that other tools are sometimes used to help the calming process, including sensory items such as weighted blankets and weighted animals (similar to life-sized stuffed animals, but heavier). Patients are encouraged to use coping strategies to return to their "wise mind".

[489] Sometimes PRN medication (for example anti-anxiety medication such as lorazepam) may be used to help regulate the patient's mood and lower anxiety levels. Use of medication in this way is dealt with later in this cause of action.

Restraint

[490] Restraint is only used if the patient poses (through threatening or assaultive behaviour) an imminent threat to themselves or others. Dr Duff referred to the different kinds of restraint, emphasising that the use of physical (or "mechanical") restraint is very rare. It has never been used on any of the applicants.[166]

[491] Dr Duff explained that "manual" restraint varies from minimally intrusive acts (such as leading a person by the arm), through to "figure-four" restraint (involving two staff controlling the arms of the patient), wrist locks (which involve manipulating the wrist joint in a way that does not cause pain if the patient does not struggle but will cause pain in the event of resistance, while limiting the risk of damage to the joint) to the most extreme end of the spectrum, where a patient may be taken to the ground.

[492] She said that in the Pōhutukawa Unit, the most common form of restraint is where a three person team uses an approved technique which allows two members of

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[166] Although Mr M spoke in his DVD interview about the use of a "special belt" on other patients so that they would not hurt themselves.

the team to immobilise the patient's arms, whilst the third member of the team maintains overall control, reassuring the patient about the process and ensuring that the head and airway is always protected.

[493] Once a patient has been restrained, he or she is escorted to the High Care area and, if safe to do so, is seated on a padded bench with a staff member on each side. Staff generally release the pressure on the wrist joints once the patient is seated, although they keep the wrist locks applied. The patient is encouraged to calm down. When it is thought that they have calmed to the extent that they no longer pose an immediate risk, the locks are released entirely.

[494] At that point, Dr Duff said that staff will sit with the patient and try to help him or her understand what has just happened by using a "chain" analysis (which is aimed at helping patients understand cause and effect) and also to learn from the incident, by helping them develop and use their own coping strategies. Depending on the severity of the disturbance, a patient may be managed in the High Care area for a period of time before being gradually re-integrated onto the ward.

Seclusion

[495] As the definition in the IDCCR Act suggests, seclusion is the placement of a person alone in a room or area, at any time and for any duration, from which he or she cannot freely exit.

[496] Again, seclusion is used only when it is considered necessary and appropriate for the safety of staff and other patients, and for a patient's own well-being. Seclusion is used only as a last resort, when staff feel that they cannot safely manage the patient in the open High Care area. All instances of seclusion are required to be recorded and these records are kept with the patient's file.

[497] Dr Duff explained that sometimes a dysregulated patient will be secluded for a short period of time until alternative strategies or resources can be found. The most obvious example is where a patient may be secluded for a short time while the necessary staff are brought from other parts of the Unit, or from other units entirely,

[498] There are also occasions when a patient is seen to pose such a high risk to staff that he or she is unable to be safely restrained in the High Care area and is secluded for a period to give him or her time to calm down. The thinking is that time away from others (one or more of whom may have been the focus or cause of the patient's distress) helps to reduce over-stimulation and is an important part of the process of a patient regaining control over his or her own behaviour and, ultimately, self-calming.

[499] Whenever a patient is secluded he or she must be kept under frequent observations according to defined policies. Where additional concerns are present observations may be increased further.

[500] Dr Duff also explained the nuances of seclusion in practice. She said:

> … seclusion continues until there's a period of stability where the individual's felt to be assessed to be safe to transition back into the main unit. So they … don't just remain in seclusion and nobody talks to them. So they will be in seclusion, they will come out from seclusion, they will spend time in the lounge, they will talk with staff, they will be reviewed by doctors, their therapist may come in to see them, the DI may come in to see them, and all of that time assessments will be continuing about how much they've regained stability or how much they're still close to a flashpoint and likely to again become agitated and aggressive, and for some of them it does require a … a period of calming in which they remain in … the seclusion area, with increasing amounts of time being spent out of seclusion but still in the High Care area and still then technically under seclusion. So … the reintegration process will take longer … and again, it's a generalisation because some people will just spend a brief period of time in seclusion, … but in some cases there's this ongoing instability, ongoing distress, ongoing anger, ready to flare up again, and rather than provoke further instances requiring restraint further periods in that low-stimulation environment, which includes periods of time in seclusion, may well be carried out.

[501] Notwithstanding the reality that interactions with others may well occur during the seclusion process or that a patient may move in and out of seclusion strictly so-called, Dr Duff also explained that seclusion events are recorded as continuous. She said:

> So the seclusion area, as you saw, has a small but an outside courtyard area, and so they – commonly the doors would be opened and they would be allowed to move into that courtyard area every time they were out of the seclusion room itself into the High Care space. And … unless they're physically fighting us in the moment, then they would normally come out of the seclusion room to have some exercise, to have meals, to use the toilet, intermittently throughout the day. The seclusion doesn't formally end unless the person has remained outside the seclusion for a period in excess of an hour,

> … which doesn't mean they are in their room the entire time, but it means unless they have been out for periods longer than an hour, they will count it as being continuously in seclusion.

[502] Dr Duff said that where necessary for safety, patients change into a stitched nightie when they are in seclusion. She explained:

(a) the gown is made of reinforced material so it cannot be torn into strips to be used as ligatures or to bind;

(b) where possible, patients are asked to change into the stitched nightie themselves (rather than have staff do it for them); and

(c) if a patient is not able to change into the stitched nightie themselves, staff will help. Staff "try to be gender sensitive to the privacy and dignity of the individual, of course, and so generally there would not be female staff present". She continued, "The principle would be that it would be male staff who would do that".

Management following an incident of challenging behaviour

[503] Once the immediate incident has been resolved, and the patient's mood has calmed, staff work with him or her before he or she is transitioned back to the ward. The staff conduct a debrief with the patient to find out what caused the incident and to suggest different ways of managing anger and anxiety and to reinforce social stories around positive behaviour. Depending on the assessment of the patient's mood and any ongoing risk, the patient may be kept in the High Care area for a time with goals being set for the patient to achieve before transitioning out.

[504] Once a patient is assessed as ready to leave the High Care area, he or she may be transitioned into the assessment area of the Unit prior to full reintegration into the main Unit. The assessment area is a two bedded cluster on the unit with its own lounge and courtyard potentially offering a less stimulating, less anxiety provoking transition.

[505] Staff may also continue to observe the patient and assess their risk at various levels of intensity on the main unit. "Constant" observations allows for two or more

staff to closely support a patient within arm's reach, whilst "special" observations assigns a single staff member to observe a service user within line of sight. During this time patients may or may not participate in activities in the ward, depending on their risk. Once perceived as no longer a risk to other patients, staff or themselves, the patient can integrate back into his or her regular cluster and recommence regular daily activities.

Reduction and elimination of seclusion

[506] As noted earlier, both WDHB and CCDHB are working towards reducing the use of seclusion and restraint for forensic patients. This is an ongoing process. Equally, however, there was evidence that eliminating the use of seclusion may lead to an increase in other practices which have the potential to be equally (or more) distressing. By way of example, Dr Duff observed that if seclusion was prohibited then an increased need for (longer lasting) physical restraint, or for chemical restraint (which is presently prohibited) might arise.

Record keeping and debriefing

[507] Matters relating to record keeping of seclusion and restraint episodes are reviewed in regular audit reports. Dr Barry-Walsh noted that episodes of restraint and seclusion are recorded on multiple forms (seclusion forms, incident report forms, and progress notes) so a fairly accurate picture of the use of seclusion and restraint in respect of each of the applicants was available.[167]

[508] As well, instances of seclusion are followed by a debriefing process which can, in turn, result in changes to a patient's healthcare plan or behaviour and management plan. And Dr Duff said:

> Generally we try to critique all of the uses of seclusion and indeed of restraint or other critical incidents and would try to learn from them so some of them we can look at and say we got that 100% right. Some of them we can look at and say no, we could have done that better. It's the purpose of critiquing and of learning and of trying to improve.

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[167] There were, undoubtedly, gaps in the documentary records, in part due to the time-span of the claim.

Night safety

[509] A night safety plan typically involves locking a patient in his or her bedroom between 9 pm and 7:30 am. The patient is, however, permitted to exit their room at any time by way of pushing a call button, unless doing so would immediately jeopardise safety. While such a procedure does appear to fall within the IDCCR Act definition of "seclusion", the MHCAT Act does not define the term.

[510] In 1995 (prior to the enactment of the IDCCR Act) the Ministry of Health issued Guidelines entitled *Night Safety Procedures*. Those guidelines distinguished night safety from seclusion on the basis that it:

(a) is not governed by s 71 of the MHCAT Act;

(b) is used only at night, while clients are mostly asleep;

(c) is used regularly for safety purposes; and

(d) uses the person's usual bedroom, with its normal features and contents rather than a specially designated seclusion room.

[511] Nonetheless, most of the procedural safeguards around the use of seclusion were incorporated (with necessary modifications) into these Guidelines. For example, the Guidelines require regular observations to take place, records to be kept and specific clinical approval each night.

[512] The HDSSA Restraint Minimization and Safe Practice Standards 2001, state that "night safety orders" as being covered by the standards, while also noting that:[168]

> The legality of the use of these practices which are not specified under the Mental Health (CAT) Act is not always clear.

[513] The Standards then state that:[169]

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168 *2001 Restraint Standards*, above n 159, at [1.3.12].
169 At [1.3.12]

> Organizations shall develop clear policies and procedures to guide service providers and seek legal advice to ascertain if the practice they are specifying is lawful.

[514] By contrast, the 2008 *Restraint Minimisation and Safe Practice Standards* state that:[170]

> 'Night safety orders' are not covered by this Standard. 'Night safety orders' is a term used to describe the practice of locking the entry to a consumer's bedroom overnight at the request of the consumer or locking the entry to an inpatient unit or residential service at night for the general safety of all.

[515] The relevant evidence was that:

(a) both CCDHB and the WDHB did have such policies and procedures over the time-span of the claim.

(b) patients are not subject to night safety as a matter of course. For example, Mr C and three other patients at the Pōhutukawa Unit did not have night safety orders in place at the time of hearing.

[516] As well, Dr Skipworth gave comprehensive evidence about night safety procedures, and the reasons for them. He said:

> They're an important part of our ability to maintain a safe inpatient environment during night-time when we have fewer staff working – in most of our units, which are 15 bed units, there are seven or eight staff during the daytime but only three staff working at night-time. So it's part of an agreement with unions about what numbers are necessary in order to keep the unit safe. If all patients were able to leave their rooms at night-time, there would be a requirement, a much greater requirement for staff in order to keep the ward, the unit safe.
>
> …
>
> If patients are moving from one bedroom to another at night-time without staff being aware, there are risks of vulnerable patients being abused or exploited or assaulted, physically assaulted, sexually assaulted, manipulated by other patients. We have a duty of care to keep all patients and staff safe and we do that by very carefully knowing where everyone is so we can maintain their safety and at night time the same applies. We need to know where people are and we need to have enough staff to maintain safety on the unit.

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170 *2008 Restraint Standards*, above n 158, at 7.

[517] Dr Skipworth had also conducted an audit at the Pōhutukawa Unit to ascertain the average length of time it takes between a patient who is subject to the night safety procedure calling for staff and his or her door actually being unlocked. This audit was done in response to questions about night safety raised after an NPMvisit. His evidence was that the average waiting time was less than two minutes. He said:

> … I think the principle here is that patients who are subject to a night safety procedure have an entitlement to leave their room on request. The only thing that would frustrate that would be if it was unsafe for the staff to do so and that, I would imagine, would be a very unusual occurrence. …

[518] Dr Skipworth rejected the contention that night safety amounts to de facto seclusion (or, as the applicants would have it, "solitary confinement"). He identified two principal differences. The first was that patients subject to night safety procedures are able to exit their rooms on request. The second is that night safety procedures are not about clinical management of a particular patient's mental state but, rather, about keeping all patients safe. As to which he noted that:

(a) while the patients in the Units tend to be men, there are, on occasion women in residence as well; and

(b) both Haumietiketike and Pōhutukawa Units often accommodate very dangerous patients, often on transfer from a prison environment, including those who have committed very serious violence and sexual offences.

[519] Night safety procedures also enable the Units safely to employ fewer staff at night which, in turn, enables greater resources to be spent on optimising rehabilitative and therapeutic activities during the day.

The applicants' experiences of seclusion and restraint

[520] Although the applicants' statement of claim referred to a number of specific instances of seclusion and restraint, those specific instances were not put to or explored with the relevant witnesses. Rather, the applicants' case appeared to be that any and all incidents of seclusion and restraint were in breach of s 9 and/or s 23(5). I will return to that contention later.

[521] Notwithstanding the applicants' failure to engage with specifics it must be recognised that, apart from the sexual assault allegations which underpin the first, third and thirteenth causes of action, it is the use of seclusion and restraint which is most likely to confront ideas of dignity and humane treatment. It is therefore useful, I think, to consider in more detail some specific instances of seclusion and/or restraint that were addressed in the respondents' evidence.

Mr M: 1 – 2 May 2007

[522] Most of the specific allegations involving the seclusion and restraint of Mr M referred to in the statement of claim occurred in mid-2007. The evidence was that Mr M was particularly unsettled at that time due to a particular management directive that had been given in April of that year. Due to a violent assault on a female staff member by a patient (not one of the applicants), a policy was introduced that male patients could not go on escorted leaves with female staff. Mr M's very strong preference for female staff meant that this had a significant effect on Mr M. It increased his distress levels and, in turn, resulted in him being unable to go out on leave due to his elevated mood. I have referred earlier to such events causing Mr M to get trapped in a "vicious circle" which tended to take a good deal or time and effort to break out of. And so it was that in 2007 there was an increase in the number and intensity of incidents of Mr M's aggressive and assaultive behaviour, and incidents of self-harm.

[523] The specific incident involving the restraint and seclusion of Mr M which I will address below occurred over 1 and 2 May 2007. I have chosen to set it out here because it is an incident where the respondents' key witness (Dr Duff) accepted that things might have been done better. In that sense it is the incident that is most favourable to the applicants, in terms of their claim. It was recorded in detail in progress notes, a seclusion recording form, an observation recording form and also in the multidisciplinary treatment team weekly review for the relevant week.

[524] Mr M had spent the night of 30 April/1 May 2007 in the assessment wing of the Pōhutukawa Unit due his elevated mood and threats towards staff. When he awoke he was seen to be in an agitated state. Staff spoke to Mr M through the door and asked if he was all right. He responded that he was alright but he wanted a smoke. Staff

asked Mr M for an assurance that staff would be safe if his doors were to be opened, which he gave.

[525] Mr M then exited his room. Due to a fault in the locking system on the double doors between the assessment wing and the open ward Mr M was able to push through the doors and into the open ward. He immediately began threatening staff and other patients. He ignored staff requests to come back into the assessment wing. As a result two male staff physically restrained him and escorted him to the High Care area.

[526] Mr M continue to threaten the staff and attempted to lash out at them physically. As a result, the staff restrained Mr M for 10 minutes until he had calmed down. At that point the wrist locks were loosened, although the staff continued to keep their hands on Mr M.

[527] After a short time Mr M became agitated again and started to get up in a menacing fashion with clenched fists. Staff were concerned that he would become physically violent so he was again restrained. When Mr M spat at staff, a third staff member held Mr M's head down until he had visibly calmed down.

[528] Another staff member arrived at 8am. The staff member recorded that Mr M was trying to fight the locks and was screaming at male staff saying they were hurting him, and that he was vomiting. He remained physically calm for approximately 20 minutes but became agitated when the staff looking after him changed around. He then had to be restrained again for five minutes until he eventually relaxed.

[529] Whilst Mr M was being restrained, he was offered PRN medication (Lorazepam) to calm down. He accepted this medication, although he vomited some of it up. After 20 minutes of calm behaviour, Mr M was given some space and a cigarette.

[530] Subsequently, Dr Wendy Bevin, a consultant psychiatrist, saw Mr M in the High Care area. He was not happy about having male staff members observe the interview. It was explained to Mr M that female staff did not feel safe with him while he was threatening staff, but he did not accept this logic. He asked to return to his

room but Dr Bevin advised that this was not possible due to his self-harming behaviour and threats to staff. Mr M denied self-harm, although this was evident from his observed behaviours.

[531] At the end of the interview Mr M was angry and irritable and stated that he hated Dr Bevin and did not want to see her again. Dr Bevin recorded that over the preceding few weeks there had been a steady increase in the amount and intensity of Mr M's expressions of anger with others and that self-harming behaviour had also increased over the preceding few days. The decision was made to continue to manage Mr M in the High Care area, with a 3:1 staffing ratio until his mental state had improved to the extent that he was able to manage his own self-care and to tolerate male staff without threatening to harm them or himself. The plan was to transition Mr M back into the assessment area before bringing him back onto the main ward. Dr Bevin also discussed using Mr M's "star chart" program within the High Care setting and/or using short-term goals that were achievable with the High Care setting.

[532] Later that day, while Mr M was smoking, he deliberately burned himself on the arm with the cigarette. He was asked by staff not to self-harm and reminded of more appropriate ways to express anger. He was also reminded that refraining from self-harm was one of the prerequisites for him moving out of High Care and back to the assessment area. Mr M then went to lie down in the bedroom in the High Care area. He was observed to self-harm by punching himself in the eye. A staff member intervened to stop this.

[533] Mr M continued to say that he wanted to go back to the assessment area and each time he was reminded of what he needed to do to be taken out of High Care: refraining from self-harm, showering, cleaning and being polite and non-threatening to staff. These pre-requisites were thought to provide observable indications that Mr M was no longer an acute risk to himself or others, which was the determining factor in terms of reintegration out of High Care into the main unit.

[534] At around 3 pm Mr M decided that he wanted to have a shower and change to clean clothes. He then did his star charts and agreed that he wanted to see all the stars. After his shower Mr M said that he wanted to return to the assessment area and it was

explained to him that he needed to show that he could be calm and not self-harm. He again became aggressive but eventually calmed and then asked staff to shut the door to the bedroom. He was told that that was against policy, which caused him to again become aggressive to the extent that he needed to be restrained again.

[535] He was seen once more by Dr Bevin in the High Care area. He continued to be angry about the presence of male staff and to say that he wanted to return to the main ward. It was discussed with him that he would need to go for one day with no threats and no self-harm before he could transition back to the assessment area. It was also explained that he would need to stay in High Care overnight.

[536] Dr Bevin discussed the plan for managing Mr M with staff. Staff expressed their concern about Mr M's self-harming if secluded, so the plan was for staff to manage Mr M in the High Care area with a 3:1 staffing ratio. However it was discussed that if the risk to staff increased then seclusion might be necessary. It was also arranged for Mr M to have a stitched nightgown and stitched blanket to avoid serious self-harm. He was allowed to smoke in the High Care area if he was not being threatening or indicating self-harm at that time.

[537] Dr Bevin also added 2mg of Lorazepam to Mr M's medication for that evening to help reduce his anxiety, which was thought to be precipitating his anger and hostility. Given his increasing paranoia regarding male staff that had elevated over the preceding few days, Dr Bevin decided to increase the dosage of Quetiapine to 250mg.

[538] Dr Bevin saw Mr M again at 7:30 pm that night. It was noted that he continue to be threatening towards staff saying that he would “get them” in the morning. On balance Dr Bevin assessed his risk towards others as significantly high, and enough to outweigh his risk to himself, given the security provided in the seclusion room and the lack of access to things that he could use to harm himself with. So it was decided therefore that staff would lock the door to the seclusion room overnight due to concerns about his threats to harm staff and in view of his past history of acting upon these threats.

[539] Mr M agreed to having a cup of tea and taking his evening medication, but remained angry and agitated about having male staff involved with his care.

[540] At approximately 9.15pm, Mr M began banging his hands and head against the window of the room. Between 9:15 p.m. and 10:15 p.m. Mr M continued to bang his fists and head against the window at continuous intervals with occasional breaks. At 10:30pm, Mr M asked to be let out to go to the toilet. He was directed to the urinal, but urinated in the corner of the seclusion room instead. At 11:00 p.m. M continued to bang his head and hands against the door of the seclusion room. He kept on doing that at regular intervals until around midnight, when he calmed down and went to sleep.

[541] Dr Duff reviewed Mr M the following morning at around 8:30 a.m. Mr M was able to come out of the seclusion without restraint. Mr M had visible evidence of self-injury. He was examined initially in the clinical room on the unit. An x-ray was arranged to ensure there were no fractures to his face or head.

[542] Dr Duff reviewed Mr M in the High Care area again at 7 pm on 2 May. By that stage he had calmed significantly and was talking to staff appropriately. The plan was to continue to manage in the High Care area but with the bedroom door open. If he was exhibiting self-injurious behaviour, staff were instructed to use manual restraint and that seclusion was to be avoided unless there was an acute risk of injury to staff.

[543] Mr M was managed in the High Care lounge without further seclusion for a number of days following this incident. He required a 4:1 staff ratio for safety. He continued to attempt to self-harm and to display threatening behaviour towards staff. But seclusion was avoided in order to avoid the risk of further serious self-harm.

[544] Dr Duff expressed the view that aspects of these events were regrettable, and that staff could better have managed the situation. She said that the decision to keep Mr M in the seclusion room while he continued to self-harm was (in her personal view) the wrong decision. She nonetheless accepted that, in the moment, Mr M was clearly presenting in a very intimidating manner with high levels of aggression to himself and others. The more limited number of staff on night shift made them feel unsafe to

unlock his door. But in retrospect, she said, alternative ways of managing the escalating situation could have been explored, such as calling staff from other units to assist with Mr M in the High Care lounge, rather than placing him in the seclusion room. Dr Duff said that, in her view, a mistake was made because of the severe stress staff felt in response to the level of aggression Mr M had displayed. She thought that this may have clouded their capacity to think creatively of alternative ways to manage the acute risk of self-harm at that point in time.

[545] Dr Duff's criticism was tempered by her acknowledgement of how easy it is to be critical in hindsight of decisions that are made in crisis situations. She said that on the spot decisions about whether a patient poses a greater risk to themselves or to staff are sometimes finely balanced. She said that she was aware that staff were very upset about what had happened and that one of them later sought trauma counselling as a result of the incident.

[546] Lastly, Dr Duff said that following the incident there was a thorough debrief at which it was discussed how the situation could have been managed better, and to ensure staff knew what resources they could call on to resolve these kinds of situations in the future. There was a discussion about not secluding Mr M (if possible) when he were self-injuring and managing him in the High Care area instead, even though that posed a greater risk to staff.[171]

Mr C – self seclusion

[547] The evidence about Mr C's "self-seclusion" disclosed a very different set of circumstances. Again, the relevant evidence was given by Dr Duff.

[548] Dr Duff began by explaining that Mr C's autism gives rise to episodes of extreme anxiety and anger which appear to be caused by his difficulty in anticipating the world and his poor emotional regulation. Some of the triggers to these behaviours are now known and are able to be minimised or avoided. But, she said, on occasion Mr C will still become distressed without apparent cause. He shows evidence of rigid,

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[171] A short while later, the DHB succeeded in implementing a policy whereby Mr M was never again secluded. This involved managing him instead in the High Care area with a 4:1 staff to patient ratio.

fixed, focused and obsessional ruminations, which are commonly seen in people with autism and which may contribute to some of these episodes.

[549] Dr Duff said that when Mr C becomes angry and agitated, he presents as a severe and immediate danger to others, usually to one specific person who is the target of his focused rage at that point (albeit without any obvious reason). Attempts to follow conventional psychiatric management procedures and remove Mr C to a safe area such as High Care or seclusion sometimes resulted in an increase in Mr C's distress, with a consequent escalation in his aggression. She suggested that this might be a result of his previous experiences of being arrested and taken to prison, and his fear of that happening again.

[550] Dr Duff said that Mr C has periods when he cannot tolerate the company of others and has a tendency to self-isolate. Attempts to reintegrate him into the main unit areas can result in further aggressive outbursts. So while he was in Haumietiketike he was encouraged to self-manage by secluding himself in his cluster when he felt unsafe around others. Following the introduction of that plan there were no serious assaults on staff or patients but Mr C was also isolated for long periods of time and had limited off-Unit activities. This type of management continued when he first moved to Pōhutukawa at the Mason Clinic.

[551] As previously mentioned, at the Pōhutukawa Unit, Mr C has a cluster wing to himself. The cluster is an area that would normally house two men and includes two bedrooms, a lounge, a bathroom, a shower room and a toilet. This is because Mr C is unable to share the space safely with other patients.

[552] Dr Duff said that when Mr C first came to the Mason Clinic, he would intermittently come out of his cluster unexpectedly and without provocation hit whoever happened to be in the immediate area. Afterwards, he would usually run back inside his cluster area and then barricade himself inside using whatever furniture and belongings were available to him. He would scream, swear, threaten and spit. Staff had to bolt his furniture to the ground or bolt it to the walls to stop him from throwing it at them or from using it to barricade himself in.

[553] Dr Duff said that restraint of Mr C was also problematic, for a number of reasons related to his autism. He struggled to make the logical connection between stopping his aggression and restraint ending and would tend to continue to attempt to assault staff even when restrained. As well Mr C's strength and size meant that several staff members were needed to subdue him when he was aggressive or agitated. And thirdly, the use of restraint sometimes increased Mr C's own distress in the moment.

[554] Dr Duff explained how behaviour of this kind was seen as a key barrier to Mr C transitioning to the community and to his being able to increase his preferred activities and engage in activities outside the Unit. Similar behaviours (random and sudden assaultive behaviour towards whoever was nearby) was a feature of his behaviour in the community and had resulted in the breakdown of community placements and led to him requiring a hospital level of care.

[555] Over time, Dr Duff became concerned that the times when Mr C barricaded himself in his cluster were not recorded as episodes of seclusion notwithstanding that that was essentially what they were. Dr Bevin noted a similar concern in August 2006. And in a Care Plan dated May 2007 Dr Bevin noted that Mr C's autism warranted individualisation of the seclusion policies to minimise his distress and reduce the risk of harm to him and others.

[556] As a result, Mr C's care team requested guidance from the DAMHS, Dr Simpson, about whether Mr C's cluster area could be made a designated seclusion area, with authorisation for any necessary variations from the standard policy. Dr Bevin proposed the following policy:

(a) when a patient asks have their bedroom door locked for safety, that does not constitute seclusion and the door must be unlocked immediately on request;

(b) in the event that Mr C asked calmly for his cluster door to be locked then that does not constitute seclusion and would not require seclusion forms to be completed or for a registrar or consultant to be informed. His door would have to be unlocked immediately upon request;

(c) because Mr C would then be in a locked area of the ward, he would need to have formal 10 minute checks and the time of locking and opening the door should also be documented; and

(d) if Mr C had an angry or an aggressive outburst or demanded that his cluster doors to be closed in an agitated manner, then the cluster doors would be locked. On these occasions he would be formally be regarded as in seclusion and the appropriate forms/documentation would need to be completed.

[557] On 11 June 2007, Dr Simpson endorsed that approach and designated Mr C's cluster as a seclusion area. He noted specifically that:

> …the care of somebody with autism, with their particular needs, is different from the rationale and the set up behind standard seclusion policies. Also I believe it is important to individualise seclusion care planning for people such as [Mr C] whose particular needs for a low stimulus environment for his safety and that of others are particular and different from most.

[558] Dr Duff explained that this meant that staff could then clearly differentiate between periods of self-isolation initiated by Mr C for his self-management from periods of seclusion when the staff were restricting his access to others (whether or not this had first been initiated by Mr C himself). Drawing this distinction was important for the purposes of transparency and also to ensure appropriate monitoring and safety checks. She said that the distinction between the two could be drawn simply by asking "would I feel safe letting [Mr C] out of his cluster if he asked to come out right now?" If the answer was no, then the seclusion policy needed to be put in place, which triggered the reporting requirements and time-limits for seclusion under the relevant standards and policies. This would be so even if Mr C did not want to come out of his cluster at that point.

[559] The implementation of this policy means that many of the records of Mr C being secluded, actually involve his "seclusion" in his own cluster area, as a matter of his personal choice.

[560] Following the Ombudsman's visit to Pōhutukawa in 2012, (in her NPM capacity) she described this solution as an "innovative way to manage an individual

with high and complex needs, who would otherwise be managed in the seclusion area on a semi-permanent basis".

[561] Dr Duff said, however, that over time, Mr C's clinicians came to realise that Mr C's opportunities for longer term movement back into the community would be limited by his pattern of self-isolation. She said that staff therefore adopted a new approach where they emphasised to Mr C that if he chose to self-isolate that would be respected but that if he actively attacked people outside his cluster then that would result in a period in High Care. The aim of this change was to reinforce that assaulting others was not a safe way to self-manage and better to approximate a real life experience. Otherwise, if Mr C was discharged from the hospital environment he would be at risk again of being arrested if he continued to exit his own space to assault others.

[562] This change was accompanied by the staff working with Mr C and developing "social stories" to help him understand the relationship between cause and effect. Dr Duff emphasised that this was not about "punishing" Mr C for his behaviour in the retributive sense, but was instead about helping him understand what behaviour was not acceptable or safe and that there were safe alternatives and boundaries. Dr Duff also spoke about the idea of creating an "invisible line" for Mr C at the door between his cluster and the rest of the ward, so that he now knows that when he becomes angry and aggressive, he cannot cross the line and come out and assault someone. She said that this has proved to be effective.

[563] As noted earlier in this judgment Mr C has now also progressed to the point that his furniture need no longer be secured to the floor or walls. He also has a Laz-E-Boy chair which is too heavy for him to throw at the staff, and he has a foam table which does not hurt if it is thrown. Dr Duff said that he has become increasingly communicative with the team and can verbalise more consistently when he feels in control and safe to work with staff and when he wants time away from them. There has also been a decrease in the number of occasions where Mr C becomes angry to the point of being assaultive, although incidents do still happen. Staff see it as a success that, even though Mr C sometimes still feels angry or upset and may shout, scream or

even spit at them, he does so from behind his "invisible line" and very rarely comes out of his safe area to assault others.

[564] Staff have also learned how better to deal with Mr C, and they always check with him before entering his cluster. If Mr C does not want other people around him, staff know to allow him space. Due to his specific needs, the management in his case is quite different to the management of other patients on the Unit, with greater emphasis on creating an autistically friendly environment, reducing autistic anxiety and creating structure to help Mr C feel more control over his environment and giving him a predictable routine. The use of techniques such as "social stories" (which teach about cause and effect) and sensory modulation were given as examples of this approach.[172]

Mr S

[565] The vast majority of the specific incidents relating to Mr S referred to in the Statement of Claim were not addressed in any detail with the respondents' witnesses.

[566] One example that was focused on by the applicants, however, was the reference to the use of wrist locks in a management plan dating from 2001. Dr Judson's evidence about this was:

> I think this was an effort so that if things started to get difficult so that [Mr S] was starting to assault people that it was a way of trying to manage that with the least level of restraint that was actually going to be able to manage it. It was really making sure the staff knew that you didn't sort of go in with a sort of full-on restraint and into seclusion like you might have done for somebody else who was getting out of control, but actually try and use this particular thing that would be safe in that you would be restraining him and preventing him being able to hit anybody but try to do that in a way that was not going to be too traumatic or difficult for him. So he'd be in his chair held in a way – the wrist locks is a way of sort of holding a person so that they can't easily escape but without causing them too much stress. That's the idea of it.

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172 Sensory modulation is an accepted method of reducing the use of restraint and seclusion and involves supporting patients (often in a designated sensory room/area) to gain skills in self-management and changing emotional states by using sight, sounds, smells, movement and items such as weighted blankets, dogs and/or massage chairs. It enables individuals to learn self-soothing techniques and/or change their current emotional and behavioural responses to a stressful situation. In the Pōhutukawa Unit there is a dedicated "Snoezelen" room used for this purpose. Indeed, it was in this room that Mr C's DVD interview took place.

[567] Dr Barry-Walsh denied that the use of wrist locks was "lacking in humanity and dignity". That point was confirmed more generally by Ms Medlicott in the course of her evidence, when she said:

> The restraint and seclusion practices by staff are the antithesis of violent. They are controlled, planned, and implemented to reduce risk of harm to the consumer or to others. There is a strong element of keeping all people safe, including the consumer, with the lead person in the restraint process actively monitoring the situation …

PRN and "chemical restraint"

[568] "PRN" stands for "pro re nata" or "as the thing is needed". Thus, certain medications are prescribed for the applicants not for regular use but for administration "as required" either in emergency situations or when the applicants themselves recognise that they are becoming unduly agitated or anxious, as Dr Duncan explained:

> Often, yes, in that PRN, I forget what the Latin for it is but it's as required and a lot of PRN medication is when people, when care recipients learn to recognise that they are becoming emotionally dysregulated, a lot of them will say, "I need something to calm me down," and most use of PRN medication is initiated by the client[.] … [I]n fact paradoxically I think that often having PRN medication available is counterproductive because you get to a situation where people want a tablet to fix how they feel rather than them working on it and using their toolbox of skills and there's often a conflict with people wanting a quick fix and us saying, "You need to work out ways." PRN medication is sometimes used acutely when someone is so disregulated that they're not able to agree they need to take it, but even in those situations more often than not most PRN medication is given with the person saying, "We think you need your meds right now to help you get back in control," but there is provision for intramuscular medication at times when things are out of control and the person isn't able to be compliant with the recommendation.

[569] The administration of PRN medication to the applicants potentially engages with issues of capacity and consent because its administration in emergency situations falls within the exception provided for in s 62of the MHCAT and the IDCCR Act, where consent is not required. The issue of consent to medication is discussed later in this judgment. In any event, there was no evidence of any particular instance where PRN had been administered to any of the applicants under s 62 in circumstances where the requisite risk did not exist. Rather, Mr Ellis' primary concern about PRN appeared to relate to the proposition that it was used as "chemical restraint". As noted earlier, the use of medication in that way is specifically proscribed by the *Restraint Minimisation and Safe Practice Standards* of both 2001 and 2008.

[570] Dr Duff nonetheless acknowledged the risk that PRN might be used in that way:

> So obviously there is a risk that chemical restraint becomes part of the management of somebody, particularly somebody who's very highly distressed, very violent towards others or towards themselves in their distress, and so there is always a risk that chemical restraint can become part of the end result and it's one of the reasons why the good practice guidelines say you should, you know, avoid high dose, avoid polypharmacy, so lots of different medications simultaneously, you should try and target behaviours, so, so yes, it is possible and it's something you have to kind of be conscious of and wary of and try to minimise if you feel that it is beginning to occur.

[571] A similar acknowledgement was made in relation to evidence that Mr S had, on occasions, been encouraged to ask for PRN when he was feeling particularly anxious. It was acknowledged that it was possible that he had become conditioned to ask for PRN "because it's the simplest way out" but that staff were very aware of the risk. Dr Judson said:

> From my experience of working with Mr S and the staff, I don't think that it was seen as an easy way out or looked upon and used in that way. It's possible but I don't think that that occurred.

[572] Similarly, Dr Barry-Walsh was asked under cross-examination about a specific instance in January 2011 when Mr S was given more than one dose of PRN during a two hour and 25 minute period of seclusion, after he had assaulted staff. The exchange was as follows

> Q. So he's been in seclusion for two hours, been given PRN and then he needs some more. Why?
>
> A. Well, I would assume because the first dose hadn't been sufficient and it was clinically indicated.
>
> Q. The – another possibility is he wasn't sufficiently chemically restrained.
>
> A. No.
>
> Q. PRN medication used – or any medication used for chemical restraint?
>
> A. Well, chemical restraint is not a term that I use and I'm not sure what people mean by it. If they mean by it providing, giving someone enough medication that they're physically incapable of acting aggressively because they have that much medication on board then no, that was not the practice.

Q. It was never the practice?

A. Not to my knowledge.

[573] So the evidence was clear that not only is PRN not permitted to be used as a form of chemical restraint but was not in fact so used. Those witnesses to whom the question was put were adamant that while PRN might have a sedating effect, it is administered for clinical reasons and never in a way that caused physical incapacity or to render a patient incapable of physically resisting. Ms Medlicott's evidence in cross-examination about this was:

Q. … over the past decade prescribing clinicians have been increasingly mindful of prescribing and wholesale use of antipsychotics for sedation which no longer generally occurs.

A. Yes.

Q. So it did occur?

A. Yes, it did.

Q. And when did it die out?

A. When I started working in the area 20 years ago, we were near the end of the process within the Otago and Southland regions of removing all medications that we use for the sedation side effects only. It's a very complex process, so I supported the psychological wellbeing as nurses and psychiatrists supported the health and practical side.

Q. What's a complex process? Getting them off –

A. Yes.

Q. – addictive medications –

A. Yes.

Q. – that they shouldn't have been on in the first place?

A. Yes.

Q. Yes. What caused this change?

A. The greater awareness and understanding that again, people with intellectual disabilities have rights the same as everyone else and that the mass use of sedating medications for that undesired side effect absolutely does nobody any good whatsoever. It affects their ability to learn, to participate, to develop skills and abilities, so it was a rights issue and a clinical issue.

Q. And it's just a coincidence if somebody's prescribed something now and it has a sedating effect?

A. We would love to be able to have medications that directly target psychotic symptoms without any undesired side effect. That's not yet available and there are some medications that are used particularly as required, PRN, which are for that sedating effect such as benzodiazepines, to relieve the stress at that moment.

Q. Aren't they addictive?

A. Oh, yes, they are.

Q. But they're used on request.

A. Very carefully, such as when I referred to Vaughan saying that Mr C was appropriate in his use of PRN medication, Lorazepam in particular. This was around ensuring that there wasn't an increasing pattern of use. There weren't any concerns around dependency, tolerance and so on. So it's very – people are very aware of the issues around benzodiazepines and monitor that very carefully.

Analysis of the claims

Seclusion and restraint a "solitary confinement regime" in breach of ss 9 and 23(5) NZBORA?

[574] As noted earlier, the applicants allege that seclusion and restraint were used:

(a) as a tool for punishment and control;

(b) for unnecessarily long periods;

(c) without appropriate medical supervision; and

(d) in such a way that amounted to assault and battery.

[575] The first of these (which is directly linked to the overarching proposition that seclusion constitutes "solitary confinement") was by far the greater focus of the applicants' case and I will address that shortly.

[576] As far as (b) is concerned, the evidence overwhelmingly was that:

(a) seclusion and restraint were only ever used for as long as the safety of the patient and others required it. And as noted above:

(i) some incidents of seclusion were recorded as being continuous when in fact the patient was moving between the seclusion room and the High Care area;

(ii) the seclusion records include some of Mr C's periods of voluntary self-seclusion; and

(iii) to the extent the "unnecessarily long periods" include periods when patients were asleep under night safety procedures, there are important differences between those procedures and seclusion strictly so-called.

[577] As for (c), there was no evidence whatsoever that restraint and seclusion occurred without "appropriate" medical supervision.

[578] And as for (d), restraint could only amount to "assault and battery" where the force used was not authorised by law or reasonable in the circumstances. Again, the evidence overwhelmingly was that all care is taken to ensure safe practices and practices that are the least intrusive possible. Although there was evidence of occasional injury to patients during the use of seclusion and restraint (such as an injury to Mr C's rib and carpet burns) the risk of such injury always exists when force is used. I accept the respondents' submission that the fact that injuries may result from the use of force does not displace the clinical justification for the use of such measures, or amount to a breach of s 23(5).[173] It is similarly difficult to see how steps to seclude or restrain a person which are taken in good faith and on the basis of a clinical judgment about risk, which nonetheless results in an injury, could be found in breach s 23(5).

[579] And so I put the matters referred to at [574](b) to (d) to one side. I return instead to the first and central contention about punishment and control.

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[173] By way of example this Court struck out a claim based on s 23(5) in a case where a prisoner had his arm broken during a "control and restraint" procedure when he was at risk of self-harming in *Forrest v Attorney-General* HC Christchurch CIV-2009-404-6358, 30 March 2010, at [12].

[580] As just noted, the proposition that seclusion constitutes "solitary confinement" is intrinsically linked to the proposition that seclusion has been used as a punishment. Indeed that was a major theme of this aspect of the applicants' case.

[581] The starting point is that the use of seclusion in that way is expressly prohibited. For that reason alone, lawful seclusion does not resemble "solitary confinement" which, the respondents accept, is the practice of using segregation (which is ordinarily used for protective purposes) specifically as a punishment.[174] By contrast, seclusion occurs in response to a person's risk to self or others. Patients are permitted to associate in the usual way as soon as the risk they pose is lessened.

[582] To the extent that the applicants say that they have been secluded unlawfully as "punishment" the evidence does not support it. Rather, the evidence was that seclusion and restraint have been used lawfully, and only when the safety of the patient or of others is immediately at risk, and as measures of last resort when other methods of de-escalating dangerous behaviour have failed. Importantly, Dr Webb herself accepted in cross-examination that:

(a) once de-escalation had failed and matters had developed to a point where a patient was at risk of imminent violence (whether to self or others) there was no real choice but to restrain and/or seclude;

(b) it was not the intention of staff to punish patients when they placed them into seclusion; and

(c) it would be unlikely to be possible to have meaningful or positive interactions with patients at the point seclusion was being initiated, because:

> … at the actual point of seclusion you've got somebody who is very, very angry and at that point is probably not in a state of mind that you can have a reasonable conversation with.

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174 For example, confinement is available as a sentencing option to hearing adjudicators (up to seven days) and Visiting Justices (15 days) conducting prison disciplinary hearings under the Corrections Act 2004.

[583] Dr Webb was also asked whether she could point to a particular seclusion incident in which she would say that there had been a breach of fundamental human rights for one of the applicants or whether she was simply saying that it was the totality of seclusion over time that has breached their human rights. She said:

> You see, that's the problem with this whole thing. Yes, I agree with your second statement. The problem and the challenge here is that any one incident of violence, once it's started, is probably appropriately met with a response to maintain safety by restraint and seclusion. ...

[584] For both completeness and the avoidance of doubt, however, I propose briefly to apply the s 23(5) analysis I have outlined earlier both to:

(a) the "worst case" example of Mr M's seclusion and restraint over the first and second of May 2007; and

(b) the totality of the evidence about seclusion and restraint.

[585] As far as the specific example involving Mr M is concerned the following points seem relevant.

[586] First, at the time in question Mr M was (lawfully) detained. Section 23(5) did therefore apply to him.

[587] Secondly, and in terms of whether s 23(5) was breached:

(a) the evidence was that his restraint and seclusion on that occasion was a necessary aspect of his detention, in the sense that, without it, he posed a real and immediate risk of injury to himself and to others. Keeping both Mr M himself and others safe from such injury is the fundamental purpose of his detention. By not acting protectively (by the use of seclusion and restraint) the DHB would have been be in breach of its duties as the detaining authority;

(b) relatedly, the MHCAT Act (under which he was then detained) and the relevant standards, policies and guidelines authorised his restraint and seclusion in the circumstances that arose; and

(c) there is no evidence to suggest that the whole episode lasted longer than was clinically necessary.

[588] That said, however, and even in the absence of an identifiable breach of the relevant policies and standards, it is certainly arguable that Mr M's humanity and inherent dignity was affected by aspects of what occurred. More particularly:

(a) Mr M was permitted to bang his head and hands against the seclusion room door for a period of more than two hours;

(b) he was undoubtedly particularly vulnerable due to his high level of distress; and

(c) he was visibly injured, although not (it seems) particularly seriously.

[589] Nonetheless his distress had receded sufficiently by the next morning that he was able to safely come out of the seclusion room.

[590] It is arguable that, on that occasion, the DHB failed to protect and keep Mr M safe from unnecessary harm. That was really accepted by Dr Duff when she said that it would have been better had he not been secluded and permitted to self harm in the way that he did. She suggested that, at least with benefit of hindsight, there might have been other ways of dealing with Mr M that evening.

[591] Absent any actual illegality, however, there must (as discussed earlier) be a clear and serious departure from the standard of care expected of a reasonable person in the position of the detaining authority in order to find a breach of any protective duty owed under s 23(5). And in that regard, Dr Duff's evidence is critical. She made it quite plain that the staff on duty were required to make a difficult clinical decision about whether, at that point in time, Mr M posed more of a risk to himself or to others; and depending on the answer, whether to put him in the seclusion room or not.

[592] Based on Mr M's behaviour throughout the preceding day there would undoubtedly have been a real risk to staff had he permitted to remain in the High Care area. Dr Bevin had foreshadowed earlier that seclusion might well be warranted. No

doubt the decision was also influenced by the fact that it was night-time and there were fewer staff on duty. And so the seclusion decision was made.

[593] In the end, I can only accept Dr Duff's analysis which I found both frank and searching. The reality is that there were valid reasons for staff acting as they did. The risk posed by Mr M was undeniable. The fact that, far removed from the heat of the moment, it is posited that there might have been another, better, option does not mean that the standard or care required of the DHB under s 23(5) was not met. Dr Duff very fairly accepted that the incident was regrettable. But in my view, s 23(5) was not breached here.

[594] Next, as *Taunoa* makes clear, it is possible that, notwithstanding the absence of any single incident amounting to a breach of s 23(5), the totality of a detaining authority's conduct can constitute inhumane treatment amounts to a breach of s 23(5). As I have noted, that seemed to be Dr Webb's position in relation to restraint and seclusion.

[595] But the present case is very unlike *Taunoa*. While it is true that instances of restraint and seclusion have continued over some years in relation to each of the applicants, I accept that:

(a) seclusion and restraint are not used as punishments;

(b) the risk of violence posed from time to time by each of the applicants is real and severe. Indeed it is that risk which is the cause of their continued detention;

(c) not one of the documented instances has been shown to be unlawful or not warranted in terms of risk;

(d) the evidence was that days, weeks and months can go by with no episodes of seclusion or restraint;

(e) there are numerous standards, guidelines and policies that regulate the use of seclusion and restraint and which emphasise minimisation of those practices;

(f) behavioural strategies have been put in place specifically to minimise and manage the risk of violence from the applicants and, accordingly the need for their restraint and seclusion. The evidence was that these strategies have in fact decreased that need; and

(g) record-keeping requirements provide for a high level of transparency in the use of restraint and seclusion, and allow for strict monitoring, both by external agencies, and by internal DHB bodies set up to implement strategies to reduce the incidence of restraint and seclusion.

[596] I am therefore unable to accept a totality breach here.

Night safety procedures

[597] The applicants have suggested that the practice of locking patients' rooms at night, or "night safety", is also a form of seclusion or solitary confinement. But the "solitary confinement" proposition can be dismissed out of hand, for the reasons already given.

[598] As to whether night safety procedures do or do not constitute seclusion properly so-called it must, as I have said, be accepted that they appear to fall within the (only) statutory definition. Equally, however, there are important differences because (subject to any immediate safety risk) patients are able to ask to be let out on request and (as a matter of evidence) such requests are acted on immediately. Moreover, as noted earlier the purpose of night safety procedures and seclusion are quite different. Night safety procedures respond to the need to ensure client and staff safety in an environment where patients are sleeping and staffing levels are low. It does not respond to an immediate clinical risk posed by the individual patient as required by the provisions authorising seclusion. And, in any event, it seems clear that the recording, reporting and observational safeguards which have been placed around

the use of night safety procedures mirror (subject to any necessary modifications) those which are placed around the use of seclusion.

[599] So as the respondents submitted, labels are largely immaterial here. The real issue is whether there is something about the night safety procedures which might amount to a breach of s 23(5).

[600] The signal point is that the evidence made it quite clear that night safety procedures are put in place for sound operational reasons. The DHBs have indisputable duties to all patients to provide a safe and secure environment under s 23(5). To permit patients who may well be objectively dangerous to wander around in the middle of the night and to access the bedrooms of other vulnerable patients while they are asleep would be a clear breach of that duty. Notably, no specific harm to any of the applicants relating to night safety procedures has been pleaded and nor is any such harm really conceivable. There is no basis whatsoever for a finding of inhumane treatment sufficient to engage s 23(5).

[601] For completeness, however, I record that the respondents accept that the Ministry's guidance on night safety has, from time to time, been inconsistent and confusing. That is plainly so; although in my view the inconsistency and confusion arises more around definitional issues than around the necessary procedures and safeguards. Moreover, the evidence was that the DHBs have nonetheless adopted proportionate and rational policies to manage risks at night in a safe and reasonable way, without any notable impact on the applicants. I do not take this issue further.

Absence of detailed policies about seclusion and restraint and failure regularly to review such policies

[602] Subject only to the "night safety" point just mentioned and the "Guidelines" issues discussed in the next few paragraphs, there is no evidentiary basis for this aspect of the claim. Indeed, the evidence was to the contrary. Seclusion and restraint is authorised by law for compulsory patients and care recipients, and regulated by both national and local policies. The relevant standards, guidelines and policies put in place by the Ministry of Health, CCDHB and WDHB, and the time periods in which they

applied, have been referred to above. The revision timeframes printed on each DHB policy also indicate regular review.

[603] As noted earlier, however, the applicants amended their statement of claim in the course of the hearing to suggest that the Ministry's standards and guidelines are deficient in various respects, due to:

(a) the (admitted) failure to promulgate guidelines relating to seclusion under s 148(2) of the IDCCR Act;

(b) the promulgation of guidelines by the Director of Mental Health under s 130 of the MHCAT Act when either:

(i) the promulgation power (which is conferred on the Director-General of Health) has not been formally delegated; and/or

(ii) any delegation of that power would (in any event) be unlawful; and

(c) failure to review HDSSA standards in accordance with the requirements of s 24 of that Act.

[604] Each will be addressed in turn.

Absence of s 148 guidelines

[605] First, it can usefully be observed that it was pleaded that guidelines in relation to restraint are also mandatory under s 148. But as the respondents say that is not correct and I do not address it further.[175]

[175] That pleading is at odds with the clear wording of the section. While s 61(3) says the use and recording of restraint must occur in accordance with s 148 guidelines, it does not give rise to a duty to issue guidelines and the obligation applies only to the extent that guidelines exist. Section 148(2), which is the mandatory part of s 148, does not refer to restraint.

[606] As to seclusion, however, the respondents accept that the terms of s 148(2) of the IDCCR Act are mandatory and that the Director-General of Health has failed to issue guidelines about the use of seclusion and the prescription of medication in accordance with that subsection.

[607] In terms of this (admitted) failure to comply with s 148(2), the respondents also accept that the duty is imposed for good and obvious policy reasons (having clear guidelines in relation to coercive interventions) and that it should have been met.[176] Nonetheless, they submit that:

(a) the absence of guidelines does not make the use of seclusion under s 60 unlawful, provided that it meets the criteria for initiation and termination set out in ss 60(2)-(3). Guidelines deal with operational matters and provide procedural protections rather than substantive criteria;

(b) seclusion under s 60 does not, in any event, arise on the facts of this case because the only one of the applicants who was ever subject to the IDCCR Act was Mr M. 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;[177] and

(c) procedures ensuring safety during an episode of seclusion, which reflect and expand on the guidance issued for MHCAT Act seclusion, were in place at each DHB at all times.

[608] I agree with those submissions. I do not propose to consider that issue further.

Section 130 MHCAT guidelines

[609] The applicants also take issue with the Ministry's 1992 *Procedural Guidelines for the Use of Seclusion*, although no relief is sought in respect of those guidelines.

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[176] This is underscored by s 148(3) which makes it clear that the point of the s 148(2) requirement is to permit external scrutiny.

[177] From that point on, when de-escalation efforts failed he was managed with a 4:1 nursing team sitting with him in the Pōhutukawa High Care area.

The Guidelines are said by the applicants to have been issued under s 130 of the MHCAT Act, which 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

[610] The 1992 Guidelines state that they have been developed by the (then) Deputy Director of Mental Health, in consultation with the "Seclusion Working Party" and appear to have been signed off by the Director of Mental Health (in the sense that the "Foreword" has his name and designation at the bottom). They were first issued in June 1992 (before the MHCAT Act came into force) and again in December 1992 (after the Act came into force). The seclusion recording form annexed to the Guidelines refer both to seclusion under the 1992 Act and to seclusion under its predecessor, the MHA. The Guidelines do not refer to s 130 at all. There was no equivalent to s 130 in the MHA.

[611] The applicants say (firstly) that the "sign off" by the Director evidences an unlawful delegation because:

> … it is either a legislative power, or quasi judicial power effectively authorising a detention for an unspecified period, what would otherwise be an assault and battery (restraint) or compulsory medical treatment.

[612] The applicants say (alternatively) that the Guidelines are unlawful there was no evidence of an actual delegation by the Director-General to the Director of the s 130 power.[178]

[613] In either event, the applicants say that such procedural flaws render all events of seclusion and restraint while the Guidelines were in force unlawful.

[614] I am unable to accept either of these submissions, for the following reasons:

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[178] The respondents have not been able to find any relevant instrument of delegation.

(a) the Guidelines do not purport to "authorise" seclusion. Seclusion has (since 1992) been authorised by statute, as explained above;[179]

(b) there is no reference in the Guidelines to s 130:

(i) the Guidelines appear to have been first promulgated prior to the commencement of that section;

(ii) absent s 130, Guidelines could still be issued as an administrative matter;

(iii) s 130 does not require Guidelines to be issued; and

(c) to the extent that the Guidelines were issued under s 130 and the power to issue them was delegated, such delegation is authorised by s 41 of the State Sector Act 1988.

HDSSA standards

[615] The applicants claim that the standards made by the Minister of Health under the HDSSA are unlawful in that they:

(a) are ultra vires the Standards Act 1988; and

(b) have not been reviewed in accordance with s 24 of the HDSSA.

[616] The first proposition is legally misconceived. The HDSSA standards obtain their legal force from their notification and approval by the Minister under the HDSSA.[180] The content of those standards is also governed (in an inclusive way)[181] by the HDSSA. Their vires is not determined by the Standards Act.

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179 Prior to 1992, it was referred to (and implictly authorised) in the MHA.

180 Section 16 provides that notification under s 13 of the HDSSA makes a Standard a legislative instrument and a disallowable instrument for the purposes of the Legislation Act 2012 and requires the Standard to be presented to the House of Representatives under section 41 of that Act.

181 See s 21(3).

[617] The second proposition is factually misconceived. Section 24(2) of the HDSAA provides:

> **Standards to be reviewed regularly**
>
> (1) The Minister must from time to time consult (as required by section 20) on whether the service standards for providing health care services of any kind should—
>
> (a) continue in force unamended; or
>
> (b) to encourage the providers of health care services of that kind to improve the quality of those services,—
>
> (i) be amended; or
>
> (ii) be replaced by 1 or more new sets of service standards.
>
> (2) The Minister must consult no later than 4 years after the most recent of the following days:
>
> (a) the day the approval of the standards came into force:
>
> (b) the day the approval of the most recent amendment of the standards came into force:
>
> (c) the day the most recent consultation on the standards under this section was begun.

[618] Contrary to the applicants' claims that the required reviews of the HDSSA standards have not occurred within the four year period required by s 24(2) of that Act:

(a) the 2001 Standards were approved by the Minister of Health on 11 February 2002, with an effective start date of 1 July 2002;[182]

(b) a consultation and review process began on 1 May 2006;

(c) new standards were approved on 26 September 2008, with an effective date of 1 June 2009;[183] and

(d) another consultation process began in April 2013, and the review brought to an end on 27 April 2015.

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182 See SR 2002/24.
183 See SR 2008/364.

[619] I acknowledge that s 24(2) is strangely worded. But I do not consider that it can sensibly be interpreted as importing a requirement that consultation be "completed" within four years of the most recent of the dates specified. The requirement is to "consult" within that time. In light of the potentially wide ambit of the required consultation (as to which see s 20) the proposition that the legislation sets a mandatory completion date would be administratively unworkable. It would encourage those tasked with the consultation exercise to skim over complex issues raised in order to meet a specified end date. In order to ensure that consultation was completed in a timely way it would need to begin almost as soon as new Standards are notified. For all these reasons I am unable to accept that there has been any breach of the statutory timeframes here.

Conclusions

[620] In my view no breach of either ss 9 or 23(5) has been established in relation to the use of seclusion and restraint over the period of the claim. More particularly:

(a) seclusion and restraint is not used as punishment but in response to a real and immediate risk posed to the safety of the patients themselves and to others;

(b) the risk of violence that has been posed from time to time by each of the applicants is real and significant. Indeed it is that risk which is the cause of their continued detention;

(c) although there are rare occasions which, in retrospect, staff have accepted could have been managed better, not one of the documented instances of seclusion and restraint has been shown to be unlawful or not warranted in terms of risk;

(d) there are numerous standards, guidelines and policies that regulate the use of seclusion and restraint and which emphasise minimisation of those practices. Staff are trained in accordance with those guidelines and in the safe use of restraint and seclusion;

(e) behavioural strategies have been put in place specifically to minimise and manage the risk of violence from the applicants and (therefore) the need for their restraint and seclusion. The evidence was that these strategies have in fact decreased that need;

(f) record-keeping requirements provide for a high level of transparency in the use of restraint and seclusion, and allow for strict monitoring, both by external agencies, and by internal DHB bodies set up to implement strategies to reduce the incidence of restraint and seclusion;

(g) there was no evidence supporting any suggested use of chemical restraint;

(h) night safety procedures are put in place for sound operational (risk) reasons, although Ministry guidance on its use has, from time to time, been inconsistent and confusing;

(i) the absence of seclusion guidelines under s 148(2) of the IDCCR Act does not make the use of seclusion under s 60 of that Act unlawful, provided that it meets the criteria for initiation and termination set out in that section;

(j) seclusion under s 60 does not, in any event, arise on the facts of this case because only Mr M has ever been subject to the IDCCR Act and he was not secluded pursuant to it;

(k) procedures and polices ensuring safety during seclusion, which reflect and expand on the guidance issued for MHCAT Act seclusion, were in place at each DHB at all times;

(l) there is no discernible legal difficulty with the Ministry's 1992 Guidelines for the Use of Seclusion; and

(m) the required four yearly reviews of the HDSSA standards on seclusion and restraint have, in fact, occurred.

SIXTH CAUSE OF ACTION – FIRST APPLICANT'S CORRESPONDENCE

[621] There is a short second part to the sixth cause of action which is unrelated to the more significant claims about restraint and seclusion. It alleges that Mr S was unlawfully denied phone calls and prevented from corresponding. While his claims for relief regarding telephone calls have been withdrawn, the following prayer for relief remains:

(a) a declaration that the interference with the rights to telephone calls and visits by Mr S' advocate was a breach of ss 54 and 56 of the IDCCR Act;

(b) declarations that the interference with Mr S's right to send correspondence was a breach:

(i) of s 57 of the IDCCR Act;

(ii) of section 23(5) NZBORA;

(c) a declaration that the cumulative effects of restricting Mr S's correspondence was a breach of section 14 (freedom of expression) and section 17 (freedom of association) NZBORA; and

(d) compensation of $20,000.

[622] It will immediately be apparent that the claims relating to telephone calls and correspondence bears significant similarity to matters dealt with under the fourth cause of action. They will not be dealt with again here. Moreover, the alleged breach of the IDCCR Act is untenable, for the simple reason that Mr S has never been detained under that Act.

[623] So the only remaining matter of substance is the claim that ss 14 and 17 of the NZBORA were breached.

Facts

[624] The only evidence that falls to be considered here appears to be the file note written by Dr Duncan on 1 September 2008. The relevant portion reads:

> I spoke with Jason Grundy about the letter that [Mr S] has written to John Keys [sic], Leader of the Opposition. Under the terms of the Mental Health (Compulsory Assessment and Treatment) Act 1992 any letter written to a member of Parliament by a patient has to be sent. The letter will therefore be sent. However, I don't think it is appropriate for staff to be expected to take dictation from [Mr S] so he can write to Members of Parliament about such nutty schemes.

[625] In his evidence Dr Duncan explained the thinking that underlay this note. He said:

> This was because … these letters were in furtherance of the "[S] Trust" autism unit that Mr Burgering and others were keen to develop. As I have already explained, in my opinion these plans were having a detrimental clinical effect on [Mr S] and I felt that the more he was allowed to write to people like John Key or the Ministry of Health about those plans, the greater the risk of escalation and aggression. I was also mindful of the fact that Mr Burgering and others were writing on [Mr S]'s behalf.

[626] Later, during Dr Duncan's cross-examination, there was the following exchange:

> Q. … You had concerns about Mr S having the staff being used to dictate letters to politicians.
>
> A. Mhm.
>
> Q. You said he couldn't read or write.
>
> A. Mhm.
>
> Q. So how's he going to write a letter to a politician?
>
> A. Well, he'd written to the leader of the opposition and, I think, to the prime minister and the letters were for a particular – they were to further his establishment of the [S] unit and [S] trust and it seemed pretty clear to me that him – I didn't think it was in his interests to continue on this JAG instituted process and I felt it could, it was not useful for Mr [S] to be doing it and it was taking considerable amounts of staff time. I didn't think it was necessary.
>
> Q. He's got a right to write to MPs, hasn't he?
>
> A. He's got a right, yes.

…

Q. Well, what right do you have to act as a political censor by interfering with what he wants to write to an MP? Do you have any right?

A. I thought I had more of a responsibility to [Mr S].

Discussion and conclusion

[627] Insofar as the claim invokes s 17 of the NZBORA I agree with the respondents that freedom of association under s 17 is not engaged by restrictions on writing letters. As White J held in *Turners & Growers Ltd v Zespri Group Ltd*:[184]

> …not every activity involving or carried on by more than one person will necessarily be within the meaning of "association" in this context. Some limits to the scope and significance of what may be encompassed by the expression "association" in this context is suggested by the primary meanings given by dictionaries which refer to the "action of joining or uniting for a common purpose"… The elements of "joining or uniting" and "a common purpose" do seem essential for the type of "association" protected by the Bill of Rights Act.

[628] As far as the alleged breach of s 14 of the NZBORA is concerned, there is a factual problem. Mr S's letter to Mr Key was in fact written and sent. There was no evidence that any other such correspondence has ever been stopped. And even putting to one side the clinical justification for Dr Duncan's position (namely that writing letters about the idea of dedicated service for people with autism was damaging Mr S's mental health), s 14 does not require staff to take dictation from a compulsory patient. Mr S was not prevented from having others write letters on his behalf.

[629] That part of the sixth cause of action relating to Mr S's correspondence fails accordingly.

SEVENTH CAUSE OF ACTION – MENTAL HEALTH REVIEW TRIBUNAL

[630] The seventh cause of action alleges that a statement made in a decision of the Mental Health Review Tribunal on 29 March 2007 about Mr S constituted, or was evidence of, predetermination by the Tribunal of the outcome of any future reviews

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184 *Turners & Growers Ltd v Zespri Group Ltd (No 2)* (2010) 9 HRNZ 365 (HC) at [72].

sought by Mr S. The relief sought is that the decision be quashed. The flow-on effects of making such an order were not addressed.

Facts

[631] In mid January 2007, Mr S applied for a review of his status to the Mental Health Review Tribunal. He was at that point being detained and compulsorily treated as an inpatient under the MHCAT Act. A hearing was held on 21 March 2007. Mr S was legally represented at it.

[632] In its 29 March 2007 decision the Tribunal concluded, "without hesitation", that Mr S had an abnormal state of mind of an intermittent nature, characterised by delusions (grandiose thinking) and disorders of mood (depression and mania) and perception (auditory hallucinations). The Tribunal concluded that Mr S's abnormal state of mind gave rise to a risk of serious dangerousness to others. The Tribunal certified that Mr S was not fit to be released from compulsory status.

[633] The Tribunal also recorded its view that it was unlikely in the foreseeable future to reach a different conclusion. The Tribunal said it would:

> … expect some significant change in the Applicant's clinical state (and resultant risk) in order for it to be able to find the Applicant to be not mentally disordered and thereby, fit to be released from compulsory status. This is not a case therefore where the Tribunal would expect there to be regular ongoing applications for review made to it. The Applicant's longstanding psychiatric difficulties are compounded by his intellectual disability which is of an enduring nature and by his personality which might likewise be regarded as of enduring nature.

[634] Dr Barry-Walsh gave evidence that Mr S's status had been previously reviewed by the Tribunal on or about November 2001, May 2003, and March 2004.

Discussion and conclusion

[635] I am unable to accept the submission that the Tribunal's decision constituted predetermination in any material sense. The upshot of the statement relied on was simply that, in order for the Tribunal to come to a different decision in future, there would have to be a material change in Mr S's clinical presentation. That seems to me to be not only unremarkable but inevitable, given the terms of the MHCAT Act.

[636] Importantly, too, there were other avenues of redress open to Mr S. As noted, he had legal representation at the time. He could have chosen to appeal the Tribunal's decision. He remained able to go back to the Tribunal following each six monthly clinical review. And if he wished in future to avail himself of that opportunity but was concerned about predetermination, he could have sought a hearing before a differently constituted Tribunal. Or Mr S could have at any time sought a High Court inquiry under s 84 of the MHCAT Act.

[637] This cause of action is dismissed accordingly.

EIGHTH CAUSE OF ACTION – LIVING CONDITIONS AT PORIRUA HOSPITAL

[638] This cause of action alleges that the general living conditions at "Porirua Hospital" were in breach of 23(5) of the NZBORA.[185] The pleaded particulars are:

552.1. Failure to provide a positive therapeutic environment;

552.2. Failure to provide adequate, nutritious food;

552.3. Failure to provide adequate heating, cooling and ventilation;

552.4. Failure to provide adequate lighting and space;

552.5. Failure to maintain appropriate levels of sanitation and failure to ensure the Special Patients' hygiene needs are met;

552.6. Failure to maintain Porirua Hospital to a satisfactory state of repair;

552.7. Failure to provide Special Patients with a sense of security and personal autonomy in that Special Patients are:

552.7.1. Prohibited from keeping personal belongings in their room;

552.7.2. Prohibited from wearing their own clothes;

552.7.3. Prohibited from providing and using their own bedding;

552.7.4. Are not provided with a lockable space to keep personal belongings in; and

552.7.5. Are not provided with stimulating decor in their rooms or in the communal areas of Porirua Hospital.

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[185] Although the declaratory relief sought also refers to NZBORA s 9, breach of that right is not pleaded. In light of my ultimate conclusion that there is no breach of s 23(5) there is, in any event, no prospect of finding a breach of s 9.

552.8. Failure to respect the Special Patients privacy, in particular, the Special Patients:

552.8.1. Right to undisturbed sleep;

552.8.2. Right to form and maintain intimate relationships with another person or persons in private;

552.8.3. Right to self-pleasure in private;

552.8.4. Right to family life;

552.8.5. Failure to provide the Applicants' with the least intrusive means of providing appropriate care; and

552.8.6. In breach of Articles 3,9,10,14,17,19,21,22, 23,24,25,26,27,28,29, and 30 of the Convention on the Rights of Persons with Disabilities.

553. Depriving the Applicants' of reasonable living conditions comparative to a 'home-like' accommodation, in breach of their right to reasonable accommodation in that they are entitled to not be held in punitive conditions after the punitive part of the Applicants' sentence served.

Preliminary comment

[639] I proceed on the basis that the reference to "Porirua Hospital" is intended to mean the Haumietiketike Unit at Ratonga-Rua-o-Porirua, which, as I have said, was built on the site of the former Porirua Hospital. There was little or no evidence given about any other Units at that hospital, apart from the brief view that was taken of Pūrehurehu. Nor was there any evidence about the conditions about other parts of the hospital that have long since been closed.

[640] The allegations in this cause of action relate to most aspects of daily life at Haumietiketike. The allegations about privacy and intimate relationships (552.8 and sub-particulars (2) to (6)) are dealt with under the fifth cause of action and I do not propose to address them again here.

Reasonable living conditions comparative to a 'home-like' accommodation

[641] The alleged failure to provide "reasonable living conditions comparative to a 'home-like' accommodation" is not particularised and both its generality and its subjectivity make it incapable of separate proof. It is, however, worth recording what Dr Duff said on the topic and, in particular, its relationship with "institutionalisation",

which was an overarching theme under this cause of action and which, the applicants allege, has prevented their transition back to the community. She said

> … we want people to have a view that the horizon is better, that it's – we don't want people to feel like this is a great place to stay for the rest of my life. It's an abnormal situation to be in Pōhutukawa Unit, it's not a normal life, [that's] not what we envisage for any of our care recipients and so I don't think try, I don't think we try to make it home, we try not to make it an unpleasant place to be in but we would certainly not consider that, well I would consider I was probably doing my job poorly if people liked it so much they didn't want to leave ever. That's not the purpose of Pōhutukawa. The purpose is to complete the rehabilitation so that people move forward from there.

[642] But while stressing the importance of not making the Units so comfortable that patients would never be motivated to leave, Dr Duff also spoke of the differences between the Units and the old "institutional" model:

> Although Pōhutukawa is not a home, people stay there for a long period of time. It's very personalised. There's no uniform or any unessential restrictions. We say don't wear the hoodies up inside because, again, that's gang-related antisocial behaviour that we say is going to be therapy-interfering. We can't see faces. We can't work out what's going on. But they can have sweatshirts with hoods and they can wear them up when they're outside in the courtyard or where it's cold. They're not allowed to walk about barefoot as that's a health and safety issue for us but beyond fairly limited restrictions people are allowed their own clothes. They have their own bedding. They have their own blankets and duvets. They have toys, games, consoles, posters on their walls, and again the only reason why we would interfere with those would be if they were things which we felt were going to be therapy-interfering, rehabilitation-interfering, or risk-related problems.

[643] These latter comments are also relevant to some of the remaining aspects of the eighth cause of action, which I now attempt to discuss, below.

General condition of the Units

[644] The evidence from the applicants themselves was that particular parts of the Unit were cold or boring. Beyond that, however, neither of the applicants' other witnesses gave evidence in support of this claim, and nor was any expert evidence called in relation to these matters.

[645] I accept the respondents' submission that the facilities are fit for purpose. The following matters may particularly be noted.

[646] First, the Units must all comply with the relevant standards, notably the *Health and Disability Services (Core) Standards*. These Core Standards include specific criteria that health and disability facilities must meet. Compliance with each standard must be certified by the Ministry of Health, and each Unit is audited against these standards on a regular basis.

[647] Similarly, there is oversight of the physical condition and presentation of the Units by the Ombudsman in her NPM capacity. As noted earlier the Ombudsman has, in fact twice audited the Porirua facility (as well as the Pōhutukawa Unit at the Mason Clinic) and relevantly found:

(a) there are adequate bathroom facilities in the Unit;

(b) clients have access to clean bedding and clothing; and

(c) there were no complaints about the quality or quantity of food.

[648] The only somewhat negative comment in terms of the condition of the Unit was that, although it was clean and tidy, it was looking a little "tired" in places. Looking "tired" does not come close to constituting a breach of s 23(5).

[649] Secondly, it seems important to note that aspects of the facility are designed in a particular way for safety reasons. Hence televisions are kept behind plastic shields so the screens are not damaged, and bedroom window blinds are enclosed between two panes of glass. And the design of the facilities has a therapeutic, as well as safety, purpose. By way of example only, particular features absorb sound to create a more peaceful environment.

[650] And similarly, even matters of decoration can raise safety issues; for example the use of blu-tack for affixing artwork to the walls is proscribed because it is a safety hazard.

[651] Lastly, an individual patient's presentation and preference is also relevant to matters of decoration and possessions. Mr C's bedroom (at the Pōhutukawa Unit) was more minimalist than others because he finds pictures agitating or disturbing. Indeed,

the evidence was that he had had to stop playing snakes and ladders (which, before last card, was his favourite game) because he started hallucinating about the snakes. So Mr C's room is devoid of pictures but contains a whiteboard where he is able to write lists, which are of considerable comfort and importance to him. By contrast, as Dr Duff said in her evidence set out above, and subject only to issues of safety, other patients are able to personalise their cluster as they wish.

Sanitary facilities

[652] Again, bathroom and toilet facilities are governed by, and audited against, the Core Standards, which contain specific standards in that respect. Standard 4.3 requires that:

> Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

[653] Standard 4.3 then states that the criteria required to be met to achieve this standard shall include the organisation ensuring:

> 4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

[654] The applicants made specific criticisms about access to toileting facilities in seclusion rooms. For obvious safety reasons, seclusion rooms are not equipped with flushing toilets, but instead are set up with disposable urinals, disposable bed pans and toilet paper. When a patient is secluded, they must be (and are) able to call for the immediate attention of staff. Depending on their level of risk (either to themselves or others), a patient/care recipient may be able to be escorted from the seclusion room to use the bathroom.

[655] The applicants also make allegations about toileting arrangements when they were subject to night safety orders (which are addressed more generally under the sixth cause of action). But to reiterate, the evidence was (in this specific respect) that when a patient is subject to a night safety order, they are entitled to exit their room at any

time unless this would immediately jeopardise the safety and/or security of the unit, any other service user or staff. Mr Fairley gave evidence about the ability of patient to call for staff and exit their rooms when subject to night safety orders at Ratonga-Rua-o-Porirua.

[656] As well, the applicants themselves spoke in their DVD interviews about toileting facilities available:

(a) Mr S was asked how he would access the toilet in the seclusion area. He replied "push the buzzer".

(b) Mr M said that at night staff would "unlock the door if I had to go". If he was in seclusion, " ... they unlock the doors and they take me to the toilet". He noted that some of the rooms in Pōhutukawa, "have got toilets, hand basins outside the rooms". He noted that some rooms in Kauri Unit, "with a hand basin, not in the room but outside the room, hand basin, toilet and a shower". He clarified that, "No there's a toilet in the room in Pōhutukawa Unit, some rooms got, some rooms got toilet, hand basin and shower and some of them have just got outside the room got hand basin toilet and a shower outside the rooms". If the door was locked and he needed to go to the toilet, "I just ring the bell or sometimes in the other room, there's no toilet, there's no hand basin, just ring the bell and they open the door".

(c) Mr C was asked what happens when he is in his cluster at night and he wants to go to the toilet. He said, "The toilet door will be open". If he is in the High Care area, he will "use a bottle", or "push the call button". If he is in his bedroom and it is locked at night, he said he "can press the call button" and "someone comes".

Personal Belongings

[657] I have already spoken about aspects of the claim that the applicants are not allowed personal belongings in their rooms, above. In my view the claim is simply not borne out by the evidence.

[658] Nonetheless it is relevant to note that each Unit has their own admission protocols which are designed to ensure that the introduction of a new patient into an environment with a number of other patients goes as smoothly and as safely as possible, and this can require limitations on what the patients are able to bring into the Unit and have with them. By way of example, when Mr C was admitted to the Pōhutukawa Unit in July 2006, progress notes record that: "Belongings unpacked & necessary items in his room (see property list) some items to main store upstairs".

[659] After the admission stage, staff make clinical decisions about items that may be permitted in a client's room, depending on the assessment of the safety of such items for the particular patient. It may be that personal belongings are taken away if they present safety or security issues; they may also be taken away to protect the item from being broken by a client during an episode of aggression.

[660] Decisions about whether a patient is able to have electrical items in his or her room are made by the Multidisciplinary Team on a case by case basis based on a risk assessment of the individual patient and the others in his or her immediate environment. The evidence was that, while staff try to maximise the choice the patient has with his or her belongings, decision-making has to be realistic.

Privacy

[661] Issues about patients' sexual privacy have been addressed in the context of the fifth cause of action, above. But in terms of privacy more generally, the applicants refer to a number of occasions on which the documents have recorded Mr C as saying (or, more accurately, screaming or yelling) to staff to "go away". It is suggested that this is an example of staff not respecting Mr C''s privacy.

[662] But Dr Duff's evidence made it clear that any such suggestion was based on a misapprehension. She explained that it became understood that when Mr C shouted "go away" it was always a warning sign that he was about to hit out at a staff member. And it was that realisation which prompted Dr Duff to instigate the individualised process (described earlier) whereby Mr C has learned, in these circumstances, to remove himself into his cluster (referred to as "self-seclusion") and to remain there behind an "invisible line" until he feels less stressed and agitated.

[663] The applicants have also asserted that staff unlawfully and unreasonably search their rooms. Mr M in particular expressed dissatisfaction about that, although the evidence was clear that his room was searched when it was thought that he was secreting sharp objects there with a view to self-harming or harming others. Dr Skipworth and Nigel Fairly produced the policies that regulate such searches. There is simply no basis for doubting that those policies are, again, necessary to ensure the safety and security of the Unit.

[664] Lastly, in terms of any privacy right to undisturbed sleep, the evidence was that observation protocols require that staff are able to observe patients during the night when they are asleep. This may require staff to shine a light through the glass pane on their doors. There was, however, no suggestion that staff deliberately disturb patients' sleep and, indeed, many Progress Note entries for the night shift record that one or other of the applicants was "asleep on all rounds".

[665] Nonetheless the respondents accept that there have been occasions where an applicant's sleep might be disturbed by such checks. That is an unavoidable consequence of the necessary observation policies. But in fact, the only specific incident referred to in evidence was on 26 October 2010 where the Progress Notes record that Mr M "yelled out at the 5 am staff to shut the fucken curtain". The Progress Notes do not, however, record whether it was staff that had caused Mr M to be awake at that time.

Conclusions

[666] By way of summary:

(a) the applicants did not call any evidence of their own in support of the specific allegations made in the eighth cause of action;

(b) in terms of the physical environment at Haumietiketike, the regular audits and oversight by the Ombudsman provides assurance that standards are being met. That was confirmed by the Court's own view of the Unit;

(c) claims that there was a failure to provide a "positive therapeutic environment" or a "sense of security and personal autonomy" are inherently subjective not capable of any meaningful s 23(5) analysis; In any event, there was no evidence from the applicants that they had not found the environment therapeutic or that they lacked a sense of security and personal autonomy; and

(d) any limited intrusions on the applicants' privacy, restrictions on personal belongings or access to sanitary facilities are both clinically justified and (based on the evidence I heard) relatively minor.

[667] No arguable breach of 23(5) is disclosed.

NINTH CAUSE OF ACTION – DISCRIMINATION AND ARBITRARY DETENTION

[668] The ninth cause of action is primarily a discrimination claim although it also contains certain specific allegations of arbitrary detention. These two limbs will be considered separately.

The alleged discrimination

[669] The applicants claim their detention and treatment has been discriminatory because, by virtue of the intellectual disability and/or psychiatric illness, they have been dealt with differently from "ordinary offenders". The relevant differences are said to be that:

(a) they have been detained for an indefinite period of time, whereas ordinary offenders have finite sentences;

(b) they have been detained for longer than the maximum period of imprisonment available for the offences with which they were initially charged and which led to their detention;

(c) their special patient status is only assessed and reviewed on an ad hoc basis at their request whereas the sentence of ordinary offenders is automatically and regularly reviewed by the Parole Board;

(d) the Parole Board is a judicial body whereas a non-judicial body completes the reviews of their special patient status;

(e) when a review of their special patient status takes place they are not provided with a reasons for continued detention or what must occur in order for their detention to end, whereas ordinary offenders are provided with written reasons, with criteria for their release and are afforded an opportunity to undertake courses in order to meet those criteria;

(f) there are no automatic periodic reviews of their continued detention and the criteria for terminating detention are not provided; and

(g) there is no right to a lawyer or to a hearing at these reviews.[186]

[670] In the course of his opening address Mr Ellis also contended that the ss 9 and 14 CPMIP Act pathway was, itself, discriminatory. Given that most of this part of the applicants' claim was based on the operation of the legislation itself, rather than any alleged failures to comply with it, he needed to do so.

Discrimination: the law

[671] Section 19(1) of the NZBORA provides:

> Everyone has the right to freedom from discrimination on the grounds of discrimination in the Human Rights Act 1993.

[186] As noted earlier, the further allegation that the requirement in the High Court Rules for incapacitated persons to have a litigation guardian is also discriminatory is, in my view, res judicata and will not be considered further.

[672] Section 21(1)(h) of the Human Rights Act 1993 (the HRA) provides that intellectual or psychological disability or impairment is a prohibited ground of discrimination.

[673] The test for discrimination in terms of s 19 is that set out in *Ministry of Health v Atkinson*:[187]

> [T]he 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.

[674] For differential treatment to have a "discriminatory impact", it must result in material disadvantage.[188]

Discussion

[675] The respondents submitted that the Court of Appeal's decision in *Ruka v R* makes it clear that:[189]

(a) Parliamentary sovereignty prevents this Court from engaging with the submission that the CPMIP Act itself is discriminatory and contrary to law; and

(b) to the extent the alleged discriminatory acts or omissions listed above are themselves authorised by statute they cannot be impugned as discriminatory and contrary to law.

[676] Since the recent decision of a Full Bench of the Court of Appeal in *Attorney-General v Taylor* it seems that the first proposition cannot presently stand, at least in an absolute way.[190] That said, however, in *Taylor* it was not really in dispute that s 80(1)(d) of the Electoral Act 1993 (as amended in 2010) was inconsistent with

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187 *Ministry of Health v Atkinson* [2012] NZCA 184, [2012] 3 NZLR 456 at [55].
188 At [109].
189 *Ruka v R* [2011] NZCA 404, (2011) 25 CRNZ 768.
190 *Attorney-General v Taylor* [2017] NZCA 215, [2017] 3 NZLR 24. The Court of Appeal was prepared to uphold a formal declaration of inconsistency which had been made by the High Court. But leave to appeal to the Supreme Court has since been granted: *Attorney-General v Taylor* [2017] NZSC 131.

s 12(a) of the NZBORA and could not be justified under s 5. In that way *Taylor* was very different from the present case, in which it is not accepted that the CPMIP Act fitness to plead/insanity regimes are discriminatory. And, beyond his bald assertion to the contrary, Mr Ellis did not advance legal argument on the point. But I shall nonetheless return to this issue shortly.

[677] As regards the second proposition, however, *Ruka* does remain relevant and authoritative. There, the Court said:

> [89] Mr Ellis does not, and could not, submit that Parliament is not entitled to adopt a process designed to deal with those suffering from mental or intellectual disabilities within the criminal justice system. His complaint is that the system adopted is discriminatory. He does not suggest that Part 1A of the HRA applies; and, neither of his only possible avenues for advancing that argument, s 19 of the NZBORA and s 21 of the HRA, assists.
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> [90] While s 21 of the HRA identifies intellectual or psychological disability or impairment as a prohibited ground of discrimination, s 21B(1) states:
>
> > To avoid doubt, an act or omission of any person or body is not unlawful under this Part if that act or omission is authorised or required by an enactment or otherwise by law.
>
> [91] This provision does avoid doubt if it ever existed otherwise. The HRA does not apply to or render unlawful under Part 2 any act or omission authorised or required by the CPMIP or otherwise by law. The acts of a court or a judge in conducting the hearings required by ss 9 to 14 of CPMIP Act fall squarely within the exclusionary purview of s 21(B)(1). Section 19 of the NZBORA does not advance Mr Ellis' argument. It does no more in this context than reaffirm the right to freedom from discrimination on the grounds found in the HRA.
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> …
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> [94] Finally, we add the obvious: a judge who in the performance of his or her office conducts a s 9 hearing cannot be in breach of his or her statutory oath when presiding over a hearing conducted in accordance with a statutory provision enacted by Parliament. And, for similar reasons, we cannot say that a defendant's detention under a supervised care order constitutes arbitrary detention contrary to s 22 of the NZBORA.

[678] But I return now to Mr Ellis' more fundamental assertion, namely that the CPMIP Act is itself discriminatory. In the absence of full (or even partial) argument I do not intend to deal with it in any detail. I merely record that there appear to be some quite serious difficulties with it.

[679] First, the proposition that it is disability which forms the basis under the CPMIP Act for those such as the applicants being treated differently from "ordinary offenders" is highly questionable. In *B v Waitemata District Health Board* the High Court, the Court of Appeal and the Supreme Court all held that there was no discrimination on a prohibited ground against patients held in the mental health ICU who (unlike patients in an open ward) were not able to leave the ward and to go outside the hospital grounds to smoke.[191] That was because the reason for the differential treatment was risk, not mental health status. And so too, here. The pleaded differences in treatment arise not from the applicants' disability but from the risk they pose to themselves and others.

[680] The proposition that "ordinary offenders" are not the appropriate comparator group finds further high-level support from the decision of the Canadian Supreme Court in *Winko*.[192] The Court declined to find that a statutory regime very similar to that which is contained in the CPMIP Act breached the "equality" provision (s 15) in the Canadian Charter. McLachlin J (as she then was) said:

> [79] It is far from clear to me that the State's treatment of an NCR accused[193] and its treatment of a convicted person are readily comparable for the purposes of identifying differential treatment, given the very different circumstances of an NCR accused and the unique purpose and effects of the provisions contained in Part XX.1.

[681] The Court in *Winko* went on to emphasise both the fact that it was not NCR status alone (but rather the question of risk) that rendered a person subject to the impugned regime. And the Court specifically rejected as fallacious a comparison between finite prison sentences and the indefinite detention of NCR accused:

> [93] The appellants also emphasize the "infinite" potential of supervision of an NCR accused. As alluded to earlier, this argument overlooks the fundamental distinction between the State's treatment of an NCR accused and its treatment of a convicted person. One purpose of incarcerating a convicted offender is punishment. The convicted offender is morally responsible for his or her criminal act and is told what punishment society demands for the crime. The sentence is thus finite (even if not fixed, i.e., a "life" sentence). By contrast, it has been determined that the NCR offender is not morally responsible for his or her criminal act. Punishment is morally inappropriate and ineffective in such a case because the NCR accused was incapable of

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191 *B v Waitemata District Health Board*, above n 110, 111 and 114.
192 *Winko v Forensic Psychiatric Institute,* above n 152.
193 The abbreviation "NCR" refers to a person who is not criminally responsible.

> making the meaningful choice upon which the punishment model is premised. Because the NCR accused's liberty is not restricted for the purpose of punishment, there is no corresponding reason for finitude. The purposes of any restriction on his or her liberty are to protect society and to allow the NCR accused to seek treatment. This requires a flexible approach that treats the length of the restriction as a function of these dual aims, and renders a mechanistic comparison of the duration of confinement inapposite.

[682] Moreover, the decision in *Winko* confirms that a regime such as that which is established or continued by the CPMIP Act advantages rather than disadvantages those who are subject to it. McLachlin J said:

> [81] The second consideration at this stage is whether any such differential treatment on the basis of an enumerated or analogous ground reflects the stereotypical application of presumed group or personal characteristics, or otherwise violates s. 15(1)'s guarantee that every individual is equally entitled to the law's concern, respect, and consideration. Denial of equal benefit of the law on the basis of an enumerated or analogous ground obviously raises the very real possibility that the denial may be discriminatory. Such denials are suspect. They are the sorts of denials that have historically led to discrimination. As stated in *Benner v. Canada (Secretary of State)*, … "[w]here the denial [of equal benefit] is based on a ground expressly enumerated in s. 15(1), or one analogous to them, it will generally be found to be discriminatory, although there may, of course, be exceptions" … . …
>
> [82] This case, in my view, is also one of those exceptions. An analysis of these provisions of the Criminal Code and their effect upon NCR accused reveals them to be the very antithesis of discrimination and hence not to engage the protections of s. 15(1). Part XX.1 does not reflect the application of presumed group or personal characteristics. Nor does it perpetuate or promote the view that individuals falling under its provisions are less capable or less worthy of respect and recognition. Rather than denying the dignity and worth of the mentally ill offender, Part XX.1 recognizes and enhances them.
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> [83] As this Court recently recognized in *Law*, it has long been held that s. 15(1) guarantees more than the formal equality of like treatment; it guarantees *substantive* equality. … To this end, the jurisprudence recognizes that discrimination may arise either from treating an individual differently from others on the basis of group affiliation, or from *failing* to treat the individual differently from others on the basis of group affiliation.
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> (italicised emphasis in original; citations omitted).

[683] Even accepting that a comparison with prisoners is apposite, it is difficult to see how those found unfit to stand trial and detained as special patients or special care recipients are disadvantaged as a result of their qualifying disability. More particularly:

(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 an appropriately expert people and bodies;

(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.

[684] Further factual and legal difficulties with some of the propositions underlying the allegations recorded at [669](c) to (g) above are dealt with elsewhere in this judgment.

[685] The discrimination claim is not made out.

Arbitrary detention

[686] The right to be free from arbitrary detention is set out in s 22 of the Bill of Rights Act:

> Everyone has the right not to be arbitrarily arrested or detained.

[687] In *Neilsen v Attorney-General* the Court of Appeal provided general guidance as to the concept of "arbitrariness."[194] Richardson P said:

> [34] Whether an arrest or detention is arbitrary turns on the nature and extent of any departure from the substantive and procedural standards involved. An arrest or detention is arbitrary if it is capricious, unreasoned, without reasonable cause: if it is made without reference to an adequate determining principle or without following proper procedures.

[688] In *Miller v New Zealand Parole Board* the Court of Appeal more recently considered the guarantees provided by s 22 and, in particular, the extent to which it incorporates all the guarantees provided for by art 9 of the ICCPR.[195] It held the detention of an offender sentenced to preventive detention remains lawful (and mandatory) unless and until the Parole Board held the offender no longer posed an undue risk. In practical terms, the Court concluded:[196]

> [T]his means that a detention is not arbitrary where it was in accord with the sentence imposed by the sentencing judge and the required public safety assessments had been carried out by the Parole Board in a way which accords with the parole legislation.

[689] Here, the arbitrary detention pleading essentially focuses on:

(a) directions made by the Attorney-General under s 31(4) of the CPMIP Act that Mr S and Mr M (at the end of their maximum period of detention as special patients) were to continue to be held as patients, which are said to be:

(i) an unlawful act of executive detention; and

(ii) in breach natural justice because they were made without a hearing and with no right to counsel;

(b) the system of clinical review under 76 of the MHCAT Act "which may result in a six month continuation of detention" which is said to be:

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194 *Neilsen v Attorney-General* [2001] 3 NZLR 433 (CA).
195 *Miller v New Zealand Parole Board* [2010] NZCA 600.
196 At [70].

(i) an unlawful act of executive detention;

(ii) an ex parte hearing in the sense of *R v Taito* "in that the hearing takes place on the papers, and is a denial of natural justice";[197] and

(iii) akin to a criminal hearing because "the penalty is six months detention" but where the subject has no right to a lawyer (in breach of s 23(1)(b) of the NZBORA).

[690] Declarations are sought that ss 31(4) and 76 breach both the NZBORA and the "common law right of access to the Court".

[691] In addition, the respondents did not oppose Mr Ellis raising two related (but unpleaded) issues that arose during the trial, namely that:

(a) in the case of both Mr S and Mr M the timeframes in s 31 of the CPMIP Act were not met at the expiry of half their notional sentences, rendering the Attorney-General's direction under s 31(4) (and their continued detention) unlawful; and, similarly

(b) two Court orders renewing compulsory treatment orders in relation to Mr S and Mr C made on application under s 76 of the MHCAT Act were also made after the existing compulsory treatment orders had lapsed, resulting in their subsequent detention being unlawful.

[692] The s 31 issues will be considered first, followed by the issues under s 76.

Section 31(4) CPMIP

[693] As previously noted, both s 116 of the CJA and s 30 of the CPMIP provide that the maximum period of detention for which a person can be detained as a special

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[197] *R v Taito* [2003] UKPC 15, [2003] 3 NZLR 577.

patient (and subject to the criminal justice process) is half of the maximum term of imprisonment stipulated for his or her index offending.

[694] Section 116 of the CJA and s 31 of the CPMIP then govern what is to happen on the expiry of that period. To reiterate, both sections relevantly provide that:

(a) if, before or on the expiry of the maximum detention period, a certificate by either the responsible clinician or the MHRT is given to the effect that a special patient is no longer under disability/unfit to plead then the Attorney-General must:

(i) direct that the person be brought to Court; or

(ii) direct that he or she thereafter be held as a patient.

(b) if a certificate is given before the expiry of the maximum detention period to the effect that a special patient is still under disability/unfit to plead but does not (in the clinician's view) require to be detained as a special patient then the Minister of Health, with the concurrence of the Attorney-General, must:

(i) consider whether, in the Minister's opinion, the continued detention of the defendant as a special patient is no longer necessary and, if so:

(ii) direct that the person be held as a patient;

(c) if no certificate of either kind is given before the expiry of the maximum detention period then the Attorney-General must, on the expiry of that period, direct that the person be held as a patient; and

(d) directions made by the Attorney General that a special patient be held as a patient:

(i) are deemed to be compulsory treatment orders or compulsory care orders made by the Family Court; and

(ii) have the effect of staying the criminal proceedings in which detention as a special patient was ordered and prevent the taking of any further proceedings on the relevant charges.

Executive detention?

[695] Both Mr S and Mr M have been the subject of directions by the Attorney-General in terms of (c) above.[198] That gives rise to the claim that they have been detained by an act of the Executive, which was declared unlawful by the Petition of Right 1627.[199]

[696] Although not made explicit in the two sections, the reason for the Attorney-General's involvement seems clear enough. Apart from the Courts themselves, it is only the Attorney (or his delegate, the Solicitor-General) who has the power to order a stay of a criminal prosecution, which is the effect of the direction presently at issue.

[697] I am, however, unable to accept the submission that such a direction constitutes an act of executive detention. That is because it is not only authorised, but required, by Parliament (speaking through the CPMIP Act). The Attorney-General has no discretion as to the direction he makes if the prerequisites are established; continued detention and treatment at the expiry of the maximum term is an automatic statutory consequence of a special patient order made by a Court under s 24. Moreover, the direction itself is deemed to be a compulsory treatment order made by a Court and carries with it all the procedural safeguards that come with such an order.

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198 Mr C has never been detained as a special patient.

199 Petition of Right (1627) 3 Cha 1, c 1, which remains in force in New Zealand by virtue of the Imperial Laws Application Act 1988.

Breach of natural justice

[698] Given the mandatory nature of the direction there can be no issue of natural justice either. If the relevant factual circumstances exist (detention as a special patient, expiry of the maximum detention period and the absence of a clinical certificate) a direction must be made. Affording a patient a right to be heard prior to the Attorney-General making a decision could make no conceivable difference. Release for those in the position of Mr S and Mr M is not an option under s 31; that can only occur in accordance with the clinical review procedures under the MHCAT Act.

Non-compliance with specified timeframes

[699] This aspect of the claim is based on the wording of s 30(3) of the CPMIP Act, which provides that:

> 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.
>
> (emphasis added.)

[700] It is not disputed that, in the case of both Mr M and Mr S that the Attorney-General did not make the relevant direction under s 31(4) until *after* the expiry of the maximum detention period. Mr Ellis said that, because a special patient order under s 24 only continued "during" the maximum period of detention, both the direction and their subsequent continued detention pursuant to it, was rendered unlawful. Again, however, I am unable to accept that submission, for the reasons that follow.

[701] A useful starting point is the predecessor to s 30(3), which was s 116(2) of the CJA. That subsection provided that

> If an order is made by a court pursuant to s 115(1) of this Act in respect of a defendant who has been found to be under disability, *the order shall ... continue in force until –*

(a) the defendant is brought before a court pursuant to a direction given under this section; or

(b) a direction is given under this section that the defendant shall thereafter be held as a patient.

(emphasis added.)

[702] It can immediately be seen that the point now taken by Mr Ellis would be much more difficult to advance under s 116(2), which makes it clear that although the expiry of the s 116(1) maximum period requires action to be taken under s 116, the order authorising detention as a special patient continues in force *until* such action is in fact taken. By contrast, the literal meaning of the words used in s 30(3) arguably suggests that an order made under s 24 continues in force only for so long as the maximum period of detention. But I do not regard that as the best interpretation.

[703] I acknowledge that timeliness is properly to be regarded as important because a direction under s 31(4) results in a change of status, from special patient to patient. The change of status is meaningful because it:

(a) means that the criminal proceedings against the patient are at an end; and

(b) carries with it somewhat different statutory processes whereby that status can be reviewed.

[704] But notwithstanding that importance, it cannot be right that a delay of a few days or even a week or two in making the direction means that the patient is no longer lawfully detained at all and must be released from detention. That is because, as I have said, where no clinical certificates have been issued the *only* order that can be made under s 31 is that a special patient is to become a patient which, in turn, is deemed to be a compulsory treatment order. Indeed, *none* of the s 31 options involve release. So 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. Moreover, given that criminal proceedings can only be stayed by the Attorney-General by way of direction under the section, if no direction were permitted to be made, and the former special patient was simply

required to be released, the criminal proceedings would remain live and the criminal charges would (presumably) be reactivated. Such a result sits poorly with the protective and rehabilitative focus of the regime.

[705] As well, a literal reading of s 31(4) would suggest that there is no power to give a direction under that subsection *before* the expiry of the maximum period (the wording used in the subsection is "when the maximum period … expires"). If the prior order does not continue in force until a direction is made, all directions would have to be carefully timed to coincide precisely with the expiry date. Such a requirement would be administratively unworkable.

[706] My conclusion in this respect is further underscored by the legislative history I have noted above. It seems to me highly unlikely that the transmogrification in 1992 of s 116(2) into s 30(2) was intended to involve a substantive change the law.

Section 76 MHCAT Act: the pleaded claims

[707] Putting to one side the issue of backdating for the moment, the claims about s 76 seems to be based on a misapprehension about how the section operates within the MHCAT Act.

[708] As has already been discussed, the detention of special patients is ordered by a court, first under s 115 of the CJA or s 24 CPMIP Act and then, after the transition onto civil orders, by the Family Court. The duration of such civil orders is, at first, limited to six months but can be extended by the Court. The MHCAT Act provides that it is only at the point of the second six month extension of such an order that its duration becomes indefinite. Importantly, those indefinite orders are, themselves, made by the Family Court.

[709] For the duration of the orders clinical reviews are required to take place every six months and these can lead to a clinician ordering that a patient be released. It is not the clinician who makes an order for his or her continued detention. It is simply not correct, therefore, to say that the psychiatrists authorise the patients' continued detention or, similarly, that their continued detention is an executive act. For the same reason, any comparator between a clinical review and a criminal process is inapt. So,

too, is the importation of the notion of a "hearing" (or a formal right to be heard) in the legal sense.[200] The relevant right to be heard exists in the Family Court when the orders for (indefinite) detention are made. But in any event:

(a) copies of each clinical reviews are provided to District Inspectors who are required to discuss them with the patients;

(b) there is a right to seek a review from a six monthly clinical review in the MHRT;

(c) support for such a review is available both from District Inspectors and lawyers;

(d) there are rights of appeal from Tribunal decisions to the District Court; and

(e) there is further provision for oversight by the High Court.

[710] There is, accordingly, no legal basis for the claims that the s 76 review process:

(a) results in unlawful executive detention;

(b) results in arbitrary detention;

(c) involves a breach of natural justice (ex parte hearing); or

(d) is analogous to a criminal hearing without a right to legal representation.

Section 76 MHCAT Act: the unpleaded claim

[711] There are two instances arising on the face of the documentary record which, the applicants say, involve the unlawful "backdating" of compulsory treatment orders.

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200 The review process is inherently inquisitorial, not adversarial.

[712] The first involves Mr S. The chronology is as follows:

(a) Mr S was under a compulsory treatment order that was to expire on 24 January 2002. Then:

(b) on 17 January 2002, Dr Hewland (a locum for Dr Crawshaw) wrote to the Presiding Judge at the Family Court in Porirua seeking to extend the order;

(c) on 22 January, Dr Crawshaw/Dr Hewland signed a formal "Application for extension of compulsory treatment order". It (mistakenly) recorded that the compulsory treatment order expired on 26 January 2002; and

(d) on or about 29 January 2002, a Judge extended the compulsory inpatient order. The extension was recorded as commencing on 27 January 2002.

[713] The second involves Mr C. The chronology is as follows:

(a) Mr C's compulsory treatment order was to expire on 14 September 2002;

(b) on 2 September 2002, Mr C's Responsible Clinician, Dr Judson, certified that Mr C was not fit to be released from compulsory treatment order status;

(c) on 3 September 2002 Dr Judson applied for an extension of Mr C's compulsory treatment order; and

(d) on 1 October 2002, the order was extended for a further six months by her Judge Frater (as she then was), commencing from 15 September 2002.

Discussion

[714] As noted earlier, s 33 of the MHCAT Act expressly provides that compulsory treatment orders, at least initially, expire after six months. Then, s 34 provides that:

> (a) the responsible clinician must cause the case to be reviewed under s 76, within the 14 days prior to the date on which a compulsory treatment order is to expire; and
>
> (b) if the responsible clinician is satisfied that the patient is not fit to be released from compulsory status, he or she may apply to the Court for an extension of the currency of the order for a further period of six months commencing with the day after the date on which the order would otherwise have expired; and
>
> (c) the Court is to treat the application "as if it were an application made under section 14(4)" and ss 15 and 17 to 33 are to apply, with any necessary modifications.

[715] And importantly, s 15 provides:

> **15 Status of patient pending determination of application**
>
> (1) Where the responsible clinician applies to the Court for the making of a compulsory treatment order, the patient shall remain liable to assessment and treatment in accordance with the terms of the notice given under subsection (1) of section 13 of this Act and the succeeding provisions of that section until the expiry of a period of 14 days after the date on which the second period of assessment and treatment would otherwise have expired.
>
> (2) If, after examining the patient under section 18, the Judge is of the opinion that it is not practicable to determine the application within the period of 14 days referred to in subsection (1) of this section, the Judge may, by interim order, extend that period for a further period not exceeding 1 month.
>
> (3) If the application is not finally determined before the expiry of the period of 14 days referred to in subsection (1) of this section, or within the last extension of that period ordered under subsection (2) of this section, the application shall be dismissed, and the patient shall be released from compulsory status (but without prejudice to the making of a further application under section 8A in respect of the patient at some time in the future).

[716] Section 15 therefore makes it quite clear that, subject to meeting the timeframes contained in *that* section, the "backdating" complained of is authorised.

[717] In the 2002 case of Mr S, there can be no issue of non-compliance with these timeframes:

(a) the application for extension was made on 17 January, prior to the expiry of the order on 24 January;

(b) by virtue of s 15, the order continued in force until 7 February notwithstanding the formal expiry date; and

(c) the extension of the order was granted prior to 7 February, on 29 January.

[718] It seems to me that the fact that the extension was recorded as commencing on 27 January makes no difference to the above.

[719] Mr C's case is less clear-cut. Had the issue been raised in the pleadings it may have been possible to access the Family Court file. But based on those documents that *were* in evidence the relevant timing of the steps is as follows:

(a) the application for extension was made on 3 September, prior to the expiry of the order on 14 September;

(b) by virtue of s 15, the order continued in force until 28 September notwithstanding the formal expiry date; and

(c) the extension of the order was granted after that date, on 1 October (but "backdated" to 15 September).

[720] Although that sequencing suggests that there may have been a breach of the timeframes there are matters referred to in the documents which suggest that the automatic (s 15) 14 day extension period had, in fact, been further extended by a Judge (as also permitted by s 15). In particular, Judge Frater's 1 October decision refers to

a direction having been made earlier by Judge Moss and there is also a memorandum filed by the District Inspector dated 26 September 2002 in which she states that she had been directed to file it by Judge Moss. It is therefore not unreasonable to infer therefore that an extension of the normal 14 day period was ordered. On the material before me I am not prepared to find that the statutory timeframes were breached here.

[721] But in case I am wrong in that, there is authority which suggests that a relatively minor breach of the statutory timeframes (here, three days at most) does not render detention under the MHCAT Act unlawful.[201] That view finds further support in relation to the timeframes under s 76, because s 79(3) provides an own-motion jurisdiction of the MHRT to review patients where it appears that a clinical review has not occurred. This seems to me to be a clear statutory indication that the failure to conduct a timely clinical review, though a technical breach of s 76, does not bring lawful detention to an end.

Conclusions

[722] For the reasons given above, the discrimination claims is not made out. In particular:

(a) the proposition that the CPMIP Act "diversion" regime contravenes s 19 of the NZBORA was not properly argued;

(b) in any event:

(i) "ordinary" prisoners are not the relevant comparator group;

(ii) the reason for the difference in treatment is not intellectual disability (a prohibited ground) but risk;

(iii) the regime benefits rather than prejudices those such as the applicants; and

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[201] *Re EC* [1999] NZFLR 711 (FC); *Togia v RIDCA* HC Wellington CIV 2007-485-358, 4 April 2007.

(c) to the extent that the discrimination claim seeks to impugn acts done pursuant to and in accordance with the CPMIP Act (or the MHCAT Act) those acts were authorised by law and cannot be held discriminatory.

[723] Nor do I consider that the claims of arbitrary detention are made out:

(a) the detention of the applicants has at all times been authorised by the statute and the Courts;

(b) the detention of the applicants has occurred in accordance with the law;

(c) there is a wide-ranging and mandatory system for reviewing the continued need for their detention;

(d) the basis for their continued detention has in fact been regularly and systematically reviewed; and

(e) the applicants have extensive rights of review and appeal in relation to the outcomes of those regular reviews, which they have exercised from time to time.

TENTH CAUSE OF ACTION – MEDICAL CARE AND CONSENT

[724] Aspects of the applicants' claims regarding medical treatment and consent have already been dealt with elsewhere. And as noted earlier, that part of the claim alleging medical experimentation in breach of s 10 of the NZBORA was abandoned during the trial. What then remains of the tenth cause of action has two essential threads, namely that:

(a) alleged failures to provide "appropriate medication", "prompt access to appropriate medical practitioners" or "preventative health care" were in breach of s 23(5) NZBORA; and

(b) alleged failures to seek and obtain consent for medical treatment were in breach of s 11 NZBORA.[202]

[725] That those two threads do represent an accurate condensing of the applicants claim under this cause of action can be seen from the terms of the specific relief sought under the 10th cause of action, namely:[203]

> NN. A Declaration that the inadequate provision of medical care was a breach of section 23(5) of the NZBORA; and
>
> …
>
> PP. A Declaration that the provision of medical care without consent was a breach of sections 11 and 23(5) of the NZBORA; and
>
> QQ. A Declaration that the compulsory provision of medical care without consent was a breach of section 11 of the NZBORA[.]

Alleged breach of s 23(5): inadequate medical care/inappropriate medication

[726] As Mr La Hood submitted, medication is only part of the care and treatment that patients such as the applicants receive. It is, of course, recognised that intellectual disability is not able to be "cured" by medication. And as Dr Duncan explained:

> … the [IDCCR Act] was written in ... a decidedly anti medical framework. It's a social model of disability [that] informed the drafting of the Act and the word "medical practitioner" I think occurs in the Act … in two places, … and I think that's good in that managing, or helping people with intellectual disability integrate into society, a medical model of disability is inappropriate, and in most cases medication is therefore inappropriate as a response to difficult behaviour, and so I think we have that kind of delicate balance in the role of doctors.

[727] Dr Duncan also acknowledged, however, that the idea that doctors should not be in control when it comes to intellectual disability services is a relatively new one:

> I think one of the things that's happened since the 1950s, really, with the increase in disability culture and a way of reconceptualising disability outside a medical framework has been part of wresting the idea of doctors being in control away. So I think paternalism in disability practice has become much less of an issue. But there [is]some residual, benign – what is hopefully benign

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202 I do not propose separately to address the claim that the alleged failures to obtain consent to medical treatment also breached s 23(5). I agree with the respondents that that interest is already protected by s 11. The respondents accept that detained people retain their rights under that section.

203 Putting to one side the relief that related to the abandoned s 10 NZBORA claim.

> paternalism involved in working with people with some intellectual incapacity at times. We try and minimise that as much as we can and the social model of disability where it talks about it's society that disables, not the disability, not the impairment, is really important and it's intrinsic in the way you start thinking when you work in disability systems as a doctor coming into it. I did find it quite difficult, in a way, to make that kind of transition. But it's imperative that we do that.

[728] All that being said, it is plain that medicine has played quite a significant role in the care and treatment of the applicants; it needs to be remembered that each of them is not just intellectually disabled but also has one or more mental disorders. The evidence overwhelmingly was that their respective presentations are unusually complex and their needs are high.

[729] Diagnosis and subsequent decisions about medication that responds to that diagnosis are appropriately made by highly specialised professionals. As Dr Duff explained:

> So complex people are complex to work out and sadly, you know, there is no blood test that tells us the diagnosis, there's no blood test that tells us that this one's the magic pill. There is a degree of art therefore to – that's the clinical experience that is called to bear. We get a lot of feedback from the individual, both in terms of active feedback, so lots of occasions [Mr M] himself will say, "I like this one," or, "I don't like this one," or, "I feel better on this," or, "I don't feel better on this." So obviously we ask directly with the person concerned about whether they're finding it effective or helpful or not, and then we can also deduce from observable signs as well whether things have changed.

[730] As it happens, most of the cross-examination relating to the routine use of particular medications was directed to the subsequently abandoned s 10 (experimentation) claim. The applicants called no expert evidence to support the allegations made about particular medications prescribed and their side effects. And even if they had, it could not possibly be open to this Court to second-guess the expert clinical decisions that were made over time in relation to each of the applicants.

[731] Nonetheless it may be useful by way of example to refer to Mr C's prescription of quetiapine which, Dr Duff acknowledged, is significantly above the recommended dosage.

[732] First, Dr Duff explained that when a more unusual medication plan was being considered it would require wide consultation and discussion with the patient, family members, the multi-disciplinary team and others. She said that her practice was also to discuss any novel approach with the head pharmacist.

[733] But more specifically, and as far as Mr C's quetiapine is concerned, Dr Duff's evidence was that there is research supporting the view that the recommended dose range is too low. In terms of the balance of interests, Dr Duff reported closely monitoring Mr C for side effects but observing no significant adverse change resulting from the higher dose. On the contrary, she said that Mr C's weight dropped and he had made "such enormous gains" as a result of the medication. Her clinical view was that the high dose "very clearly remains justified". There is, as I have said, no conceivable basis on which the Court could differ from her professional view, even if a contrary expert opinion been given. It was not.

Access to medical care generally

[734] In terms of the services that are generally available to the applicants in response to temporary medical events while under compulsory care, the evidence generally was that they have regular access to such services as and when necessary. Issues around such access were not greatly advanced at trial and indeed, Mr Ellis was complimentary about the on-site availability of both a general practitioner and a dentist at Haumietiketike. And although the Mason Clinic does not offer such on-site services the evidence was that audits confirmed that patients there received better than average health care. Each applicant has individual health care plans in place for his particular medical issues.

Mr C's dental treatment

[735] The only specific issue raised in relation to routine medical care that was pursued with any vigour at trial related to Mr C's access to dental care. Dr Duff gave detailed evidence about this, based on her own knowledge and on the file records.

[736] Mr C has a history of dental issues, which are exacerbated by his anxiety around going to the dentist and by a chronic history of teeth grinding. On

29 January 2007, he complained of a toothache in the lower right molar on two or three occasions. He was given paracetamol. On or about 5 February 2007, Mr C went to the dentist and received two fillings.

[737] On 9 February 2007, Mr C expressed a desire to eat healthier food, as sweets were not good for his teeth. He was offered fruit at lunch, and was agreeable to having one coke in either the morning or the evening and trying fruit juice or lemon barley for his other drink (instead of coke in both the morning and the evening).

[738] On 22 March 2007, Mr C was given two Panadol for a sore tooth. It seems he saw the dentist again in June. On 28 June 2007, a staff nurse recorded that "two of [Mr C's] teeth had eroded down due to acid in mouth ie fizzy drinks". The nurse recorded that the two teeth were sealed, and that the dentist had said that if this didn't fix the problem, root canal or extraction would be the next step.

[739] On 26 June 2008, Mr C complained of having sore bottom teeth. He was given Panadol. He said he would like to have his teeth checked by a dentist. The following day he again complained of toothache. A referral to a dentist was planned but it seems may not have eventuated at that time.

[740] A Weekly Clinical Review document dated 19 January 2009 notes that a staff member was arranging a dental appointment for Mr C. A referral to the Oral Health Unit was made shortly thereafter. It appears that an appointment was made for Mr C to see the dentist on 19 March 2009 but this appointment was cancelled.

[741] On 25 March 2009, a staff member from Hinemoa Dental clinic rang a staff member at the Pōhutukawa Unit outlining the options for Mr C's teeth. The staff member left a message with Mr C's father outlining those options. Following further correspondence, a root canal appointment was booked for 31 March 2009.

[742] When that day arrived, Mr C had some underlying anxiety about his dental appointment. He was offered and accepted PRN medication at 9:30am to reduce his anxiety. But when the time came to leave, he declined to go to the dental appointment, despite much reassurance from staff. That evening Mr C talked about not going to the

dentist. He is recorded as having said "It's important eh", "I was scared they would arrest me", "I didn't want [staff member] to drive me", and "You should have come in and made me go eh".

[743] On or about 6 April 2009 it was recognised that there was a need to address dental care funding and long term dental management. A future dental appointment was to be arranged with a North Shore dentist. On 14 April, a note was made to enquire about Mr C's next dental appointment. On or about 20 April 2009, Mr C still required paracetamol for pain. A note was also made to follow up about his next dental appointment. A dental appointment was booked for Thursday 30 April 2009. On 30 April 2009 Mr C had two root canals and a filling done. Pain medication was prescribed for the next five days.

[744] On 8 June 2009, Mr C again had toothache. Another dental appointment was scheduled for 6 August 2009. Mr C refused to attend the appointment on that day and it was cancelled. On 17 August 2009, staff enquired into the option of a mobile dentist and 10 days later, this was discussed with Mr C. He was agreeable to that option.

[745] On 8 September 2009, a dentist conducted a review of his toothache. No swelling was observed but the lower fourth and fifth teeth were tender. A dental appointment at Greenlane Hospital was arranged. Panadol was prescribed for pain relief.

[746] On 9 September 2009, Mr C agreed to attend his dental appointment that morning. He accepted a pre-med. While travelling to the appointment Mr C said he no longer wanted to attend it and began talking about wanting to go to Pukekohe instead. Because of a previous attempt at absconding it was decided best to return him to the unit.

[747] The next day, Mr C said he was still experiencing toothache. He gave various reasons for not attending the previous appointment including not being sure that the van was heading in the right direction and seeing two women at the shops and thinking that the van would get in an accident. On 11 September 2009, a referral was made to the oral health ward at Greenlane Hospital.

[748] On 28 September 2009, Mr C attended a check-up at the dentist. A follow up appointment was needed. A follow up appointment was scheduled, but had to be re-booked to 16 October 2009. On that day Mr C went to the dentist for some fillings.

[749] On 25 May 2010, the Pōhutukawa Clinic referred Mr C to the Greenlane Oral Health Service. The Greenlane Oral Health Service replied on 27 May 2010, saying that Mr C's situation was "currently being assessed for eligibility".

[750] On 27 May 2010 Mr C was advised by a dentist (by way of letter to the Mason Clinic) that he needed to have three wisdom teeth removed. The dentist was unable to do this because in his opinion it required a general anaesthetic. The requirement for a general anaesthetic also gave rise to issue of Mr C's capacity to consent to such a procedure. The issue necessitated advice and a subsequent application under the PPPR Act by Mr C's welfare guardian.

[751] On 22 November 2010 Dr Gelman wrote that "(s)ince the advent of his teeth issues) behaviour has become more challenging and frequent presumably due to the ongoing discomfort and pain he experiences." He requested a "more timeous response to setting his surgery date in order to limit his pain, and medical complications, that may arise in the interim because of Mr C's ongoing chronic infection".

[752] On 10 January 2011, His Honour Judge Fitzgerald in the Auckland Family Court directed that "the draft [PPPR Act] order is varied to provide that [Mr C] enter and attend either Greenlane or Auckland Hospital Dental Unit to undergo necessary urgent dental treatment."

[753] On 13 January 2011, the draft order was received at the Mason Clinic. Contact with Greenlane Hospital to arrange an appointment was made that day. The oral surgeon did not return to work until late January. Several follow up calls were made to Greenlane Hospital arranging a time for the dental appointment.

[754] An anaesthetic appointment was scheduled for 23 February 2011 but that appointment had to be cancelled due to Mr C's presentation. The next day Mr C's case

was then referred to Auckland Hospital instead of Greenlane hospital. Mr C was also seen by Dr Wyness. A swab was taken and treatment prescribed.

[755] In the Pōhutukawa Unit summary for the week ending 6 March 2011, it is noted that on 28 February 2011, Mr C believed, "some animal might have come from heaven and have fight with them causing tooth ache". Further, Mr C "Has been relatively more isolative over the past couple of weeks? related to pain from mouth". On 1 March 2011, Mr C attended an anaesthetist for assessment.

[756] On 9 March, a dental surgery appointment was scheduled for 9 May 2011. On that day, Mr C had five teeth extracted.

[757] On 2 August 2011, Mr C was again complaining of sore gums and teeth. Pain relief was given.

[758] Since 2013 (outside the period covered by the claim) there have been a number of outpatient reviews of Mr C's dental health. Toward the end of 2015, Mr C again underwent dental surgery and reportedly coped well with all the anaesthetic preparations and the surgery itself. He has also recently been fitted with a mouth guard to cut down on the effect of his tooth grinding and to protect his remaining teeth.

[759] Dr Duff accepted in her evidence that, in hindsight, Mr C's dental care could have been handled better. But she also said:

> It was exceptionally difficult to get dentistry. Dentistry's incredibly expensive. It's really hard to get time in the public clinic. At times the public clinic probably takes a bit more of a – and they're more likely to remove than restore. The public clinic doesn't do some of the expensive dental restorative work, so if – dentistry is not ideal. It's one of the things that we struggle with all the time. Having said that, [Mr C] has a beautiful new mouth guard to stop him wearing down his teeth, which is very good.
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> …
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> … I think strenuous efforts were made both to overcome the capacity issues and to overcome the practical issues, and to ensure that he had pain relief in the meantime, so I think a lot of effort was made.

[760] She said that she was aware of no occasion where someone simply ignored the discomfort or forgot about the discomfort that Mr C was in. She said:

> Mr C … has quite a high pain threshold, so we always took it seriously if he says he's got pain, and we always check, we always ask verbally to prompt him because he sometimes won't spontaneously tell us, so we do specifically ask whether he has any pain as well.

Medication error

[761] The only other specific issue of substance that was raised in relation to the applicants' medical treatment concerned a medication error that also affected Mr C. On 29 September 2006 he was mistakenly given another client's medication.

[762] Dr Duff's evidence about the general practice at the Pōhutukawa Unit was that:

(a) medication is administered from the clinic room where medications are stored;

(b) ordinarily patients will be called up one at a time and will come to the clinic room door and be given their medication, which is checked off; and

(c) there are two qualified members of staff inside the clinic room during medication administration times.

[763] In Mr C's case, however, there was a more individualised practice. While he would sometimes have his medication at the clinic if he was wanting to come out of his cluster and socialise (or was already out of his cluster and socialising) on that day, on other occasions he would not be made to come to the clinic area to receive his medication. Instead the medication would be taken to him.

[764] On the occasion in question, the notes show that a staff nurse took his medication in a pottle to his room and gave it to him there. On returning to the clinic the nurse realised that she had taken the wrong pottle of medication to Mr C. Dr Duff said that the clinical notes indicate that the error was identified straight away and that the staff nurse then followed the mandated process of speaking to a doctor immediately about what the likely negative effects would be and whether anything needed to be done to ensure Mr C's safety. She acknowledged that this was a significant and serious

medication error and that, as such, it was taken very seriously and dealt with thoroughly and properly.

[765] Mr Ellis put it to Dr Duff that Mr C hadn't been given the opportunity to express a view about what had happened or been given the opportunity to make a complaint. But Dr Duff confirmed that Mr C would have been told about what had happened in a way that had meaning to him, and that the internal complaints process was "very well known to all service users and very well used." More specifically, she said:

> … he will have been told, "We've given you the wrong tablets. These are your right tablets. You have to let us know if you're not feeling okay. We'll keep a close eye during the day." So it would have been a fairly basic level of information.

[766] The evidence was that medication errors like this were the rare exception rather than the general rule. Dr Duff confirmed that there were systems in place to minimise the risk of medication errors occurring. She pointed out that Mr C is administered medication two or three times a day every day and, over the more than 10 years that he had been in the service he would have had "10,000 administrations" of medication. She said that when errors did occasionally occur, steps are taken to improve practice to reduce the risk of similar errors. In this particular case, however, she said the system had been safe and it was the deviation from the standard system that had caused the mistake. She noted that there had been appropriate "remediation" with the individual nurses concerned.

Conclusion

[767] In my view the single instance of medication error in Mr C's case set out above does not come close to being a breach of s 23(5). I do not propose to discuss that further.

[768] As far as Mr C's dental care is concerned, it was accepted by Dr Duff that there was a duty to look after his teeth and that there were aspects of what occurred which might have been handled differently, although she also rightly said that there is "always something that could've been done better." As noted earlier, she said that it had simply not proved possible to get a dentist to come to the Unit by way of some

form of outreach service. As well, some of the delays in getting Mr C to see a dentist were because he was unwilling to attend appointments due to anxiety, and they had to be rescheduled. And the need to obtain a PPPR Act order prior to administering a general anaesthetic (because Mr C could not give informed consent) also caused delay.

[769] So in terms of whether the dental care Mr C did receive (or did not receive) amounted to a breach of 23(5), I agree with the respondents that the DHB's obligations were met. More particularly:

(a) His oral surgery was a major procedure requiring general anaesthetic. There is no evidence he was required to wait for an unusually long period. It was submitted and it is more-or-less self evident that needing to seek an order under the PPPR Act added a further layer of complexity. There is no evidence that any delays in that resulted were caused by the respondents.

(b) The other, lesser delays in treatment were largely caused by Mr C's refusal to attend appointments or his becoming dysregulated en route. The evidence suggests that he received as much support as possible in an attempt to ensure that that did not happen.

[770] No breach of s 23(5) has therefore been established.

Alleged breach of s 11 NZBORA: consent to medical treatment

[771] Section 11 of the NZBORA simply provides:

> Everyone has the right to refuse to undergo any medical treatment.

[772] As noted earlier, both the MHCAT Act and the IDCCR Act generally stipulate that written consent to treatment is required, although there are exceptions provided for.[204] Those exceptions (in the MHCAT Act) are:

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[204] Similarly, the Health and Disability Consumers' Code of Rights contemplates the giving of medical treatment to a person who is unable or unwilling to give informed consent, in certain circumstances.

(a) within the first month of being subject to a compulsory treatment order (although consent must still first be sought "wherever practicable"): s 59(1) and (4);

(b) where a second opinion first confirms the proposed treatment as being in the best interests of the patient: s 59(2)(b); and

(c) where it is immediately necessary to save a patient's life or to prevent serious damage to the health of the patient or to prevent the patient from causing serious harm to him or herself or others: s 62.

[773] It is not disputed that the applicants have, on occasion, received medical treatment without their consent pursuant to these exceptions. The only way in which the lawfulness of such treatment could be challenged is if:

(a) informed consent could have been sought but was not; or

(b) the circumstances in which treatment may be provided without consent did not exist.

[774] Put simply, however, no evidence to support either one of these scenarios was produced. It may nonetheless be useful to say a little more about the issues of consent and capacity generally, and specifically in relation to the applicants.

Informed consent and capacity

[775] The concept of consent in a medical context necessarily means informed consent. In turn, it is accepted that informed consent, requires that:

(a) relevant information must be disclosed to a patient;

(b) the circumstances in which the decision is made should be free from coercion; and

(c) the patient must be able to use the information provided in order to come to a decision.

[776] It is principally this last requirement that imports notions of competence or capacity.

[777] The concept of capacity is not defined in the relevant legislation. The evidence was that the orthodox definition of capacity requires:

(a) the ability to understand relevant information;

(b) the ability to appreciate the nature of the situation and its likely consequences;

(c) the ability to manipulate the information rationally; and

(d) the ability to communicate choice.

[778] As the respondents' witnesses made clear in their evidence, however, consent and capacity operate together, on a continuum. For example Dr Duncan said:

> The sliding scale is something that we have in medicine all the time, that where you're considering using a treatment that is considered low-risk, it's mainstream and it's very – you know, and it has few side effects, then there are less issues around capacity than if one is looking at doing some kind of particularly invasive operative procedure or using a medication well outside its normal clinical indications. Then if one is looking at doing that, one would be expected to have to establish a high level of understanding of the condition and the projected treatment and the risks associated, that may be associated with it. So in that sense the sliding scale of capacity is something that's in play all the time.

[779] Self-evidently, an individual's competence or capacity might vary over time, and depend on the circumstances.

[780] Dr Duff was also careful to explain that medical staff do not confuse compliance with consent. By way of example, she said in response to a question about whether Mr C was generally compliant about taking this medication, she said:

> Yes he's very compliant with medication, but again compliance with medication isn't the issue because I could give [Mr C] … any medication … [and] he would take it for me, that's not informed consent so compliance shouldn't be mistaken for informed consent.

[781] And Dr Duff also said that even where a clinical view is formed that a patient lacks capacity to consent it is best (and usual) practice to discuss proposed medications with them, within the limits of their competence. Accordingly, even those patients who do not have capacity will take part, and be involved, in decisions about their medication.

[782] The statutory process that is to be followed in the absence of informed consent was also explored with Dr Duff. In answer to a question about whether the MHCAT Act required a process of second opinion before treatment without informed consent could be given, she said:

> Yes … reviews are carried out every six months and as part of that review the need to remain under the [MHCAT Act] is addressed and the continued consent to treatment is also sought and documented. A clinical report is prepared for the Director of Area Mental Health Services and in Mr C's case although he would quite happily sign the form and there's a form that needs to be signed, we have quite a few patients who will be very paranoid about signing the form but will verbally say I'm quite happy to take it but actually we do need the form signed as well. So [Mr C] will cheerfully sign the form but, in my opinion, doesn't really understand what medication he's on and what the risks and benefits or taking it or of refusing might be. So a second opinion is required in cases where consent is not forthcoming or where valid consent cannot be obtained and there is no welfare guardian or other duly appointed person who has authority to consent on behalf of the individual.

[783] Overall, the respondents' evidence made it clear that the mere fact that a person has a particular status (as a special patient or a compulsory care recipient) does not alter the presumption in favour of that person's capacity to give informed consent. There was no evidence to suggest that, other than in times of emergency (when one of the applicants was presenting a danger to himself or others) the applicants' intellectual disability was ever regarded as obviating the need to obtain and consider their views about and, where possible, obtain their informed consent to any proposed treatment.

[784] More specifically, and in terms of the capacity of each of the three applicants to give informed consent to treatment, the evidence was that:

(a) The capacity of Mr S to consent changes over time. As Dr Barry-Walsh explained:

> So personally I liked, and [Mr S] liked, often to talk about his medication, and we would do that. If I felt that there was a reason to change, usually a dose of his medication, I would discuss that with him. If a more major change was required, you have to consider section 59 because his capacity to consent wasn't clear and did fluctuate.

(b) In general terms, Mr M was regarded as having the capacity to give (or refuse) consent to medical treatment. Dr Duff described how he had shown himself competent to make decisions about his medication and to refuse medication if he considered he was taking too much or if he did not wish to take certain medications at various points. The upshot was that Mr M was rarely administered medication against his express will and, even then, only in emergency situations. Staff actively involved Mr M in decisions about his medication which was a reflection of a wider approach of helping Mr M to be back in control of his choices.

(c) Mr C's capacity was not as great as Mr M's. Dr Duff said:

> … I go and have the discussions with [Mr C] on each occasion … but in my view he …can't weigh up pros and cons of taking the medication, doesn't understand the side effects when I go through them with him so yes in my view he's not being competent to consent, and as I say sometimes he'll sign the form but even on the occasions where he signed the form I have also indicated that although he signed the form this isn't an informed consent, he's signing a form rather than giving informed consent to the medication.

Conclusion

[785] The purpose of an order under MHCAT Act is to authorise the compulsory assessment and treatment of mental disorders that give rise to risk to self or others. Within the assessment period and first month of a subsequent order, treatment is as directed by the responsible clinician, regardless of the patient's views. At all other times, consent to treatment should be, and is, sought where possible. Section 59(2) clearly anticipates the service provider will first explain the treatment and seek the

patient's consent in writing, before resorting to seeking a second opinion from an approved psychiatrist.

[786] While a compulsory patient may refuse treatment, his or her treatment will nonetheless be lawful if s 59(2)(b) has been followed. Similarly, if s 59(2)(b) is followed the treatment of a patient who does not have the capacity to consent will also be lawful. And as noted at the outset there was no evidence of any specific instance where consent could and should have been sought but was not. On the contrary, the evidence was that all the relevant clinicians were acutely conscious both of the applicants' varying capacities to consent, and (regardless of capacity) involved them in decision-making about their treatment as much as circumstance, and their respective disabilities, permitted.

[787] But the short point is that treatment explicitly authorised by law does not breach s 11 NZBORA.

ELEVENTH CAUSE OF ACTION – REVIEW AND COMPLAINTS PROCEDURES

[788] The eleventh cause of action alleges that the applicants' detention is arbitrary and in breach of s 22 of NZBORA because they do not have access to appropriate complaints procedures, and that the statutory processes whereby their status is reviewed and monitored are inadequate. There are 13 pleaded particulars:

> 566.1 Failure to periodically review the Applicants' continued detention as Special Patients or Care Recipients at regular intervals, automatically as of course, without requiring the Applicants to request the review;
>
> 566.2 Failure to have a proper review by an independent judicial body of the lawfulness of the Applicants' continued detention;
>
> 566.3 Failure to advise and/or afford the Applicants of the right to obtain a second opinion from a medical practitioner in respect of the medical assessment;
>
> 566.4 Failure to systematically review interrogation rules, instructions, methods and practices, and arrangements for the custody and treatment of Special Patients or Care Recipients, in breach of Article 11 CAT;

566.5 Failure to give the Applicants their rights under NZBORA prior to undertaking any medical assessment which forms the basis of their continued detention;

566.6 Failure to provide the Applicants with the right to be heard and to question in person, and/or through legal representation, during the "proceedings" determining their continued detention;

566.7 Failure to provide the Applicants with legal representation in respect of the medical assessments;

566.8 Failure to provide the Applicants with written and/or verbal reasons for their continued detention;

566.9 Failure to provide the Applicants with the criteria for termination of their continued detention;

566.10 Failure to provide an effective and confidential complaints procedure;

566.11 Failure to provide procedural safeguards for the Applicants' liberty;

566.12 … breach of Articles 12, 13, 14, and 15 of the Convention on the Rights of Persons with Disabilities; and

566.13 … breach of the Code of health and Disability Services Consumer Rights in that it is a breach of the Right 10 – Right to Complain.

[789] This cause of action also attacks the lawfulness of HCR 4.30 but that issue has been dealt with above.

[790] I propose to deal with each of the pleaded particulars in turn.

Failing periodically, regularly or automatically to review the basis for the applicants' continued detention

[791] There is simply no evidentiary basis for this contention. On the contrary, the evidence was that the applicants have continually been reviewed in accordance with the statutory requirements.

[792] By way of example only, and in terms of the required six monthly clinical reviews:

(a) Dr Duncan's evidence confirmed (as did the documentary record) that the statutory requirements around the review process are met:

> … when the responsible clinician considers the person no longer has a mental disorder as defined in the Act, they must immediately release that person from [the MHCAT Act]. There is – so that's the main mechanism and at every six month interval there is a statutory review at which point the responsible clinician has to inform the Director of Area Mental Health Services that they consider the person still does have a mental disorder and requires compulsory – still requires compulsory assessment and treatment. … [A]nd at that time the, that, the certificate is sent to a number of people, including District Inspector, primary caregiver if there is one, and any of those people, and the patient can at that time and at any other time appeal to the Review Tribunal for a review of the order, and the Review Tribunal is tasked with deciding whether or not the person remains mentally disordered. There's also a mechanism for judicial review of that decision.

(b) Dr Duncan confirmed that if such a review was late or did not occur, the patient could go to the Mental Health Review Tribunal:

> … a person can make an application to the Review Tribunal at any time once the order's been in place for six months and they can ask to be reviewed by the Review Tribunal, I think, at six monthly intervals thereafter and most review tribunal hearings are actually triggered by the patient themselves, sometimes as a consequence of receiving the six-monthly review because there's a requirement also for the District Inspector to visit the patient at that time and discuss the review and ask them when they want a mental health tribunal review or not.

(c) In terms of a patient's input into the six-monthly review process:

> … during those reviews the person's views are obtained as part of that review … you may find specialist assessors reports and they'll detail the views of the person themselves in relation to whether they believe they still need to be cared for as a care recipient but that is not the sole issue that is taken into account by the specialist assessor and by the care co-ordinator and care manager that are writing to the Court on that review.

(d) And as to the thoroughness of the review process:

> … So basically what will happen is that when a review is due a care co-ordinator will appoint a specialist assessor for the purpose of that review. That specialist assessor may or may not have done a review for that client previously, so if they haven't met them before they will go and meet with them and introduce themselves. They will spend quite a period of time with that client but some clients don't like to spend long times with people, some of them are more comfortable than others. They'll sit there, they'll often talk with their families, families will often come to a review meeting as well, or a welfare guardian might also attend that meeting and then they will, the specialist assessor will leave that meeting, they will go away and

> collect a lot of data from the service, like incident reports, they'll talk with family members or staff members in relation to any incidents that have occurred and they may ask to meet with the client again, it depends on how well they know that person and then they'll draft their report for the Court.

[793] Dr Duncan also gave evidence about the other, less formal reviews of patients which occur on a daily, weekly and monthly basis. He said:

> … people are being seen more often than once every six months and … every time the responsible clinician sees them they're meant to consider whether the person still meets the definition for mental disorder. The intensity of follow up will be dependent on the clinical condition and in the case of inpatients one would expect the responsible clinician to be seeing the person every week or more frequently.

Failing to provide a review by an independent judicial body of the lawfulness of the applicants' continued detention

[794] Again, there is no evidentiary basis for this allegation. Review and appeal rights involving the MHRT, the Family Court and the High Court exist under both the IDCCR Act and the MHCAT Act. There is nothing whatsoever to suggest that the applicants have been prevented from exercising those rights. Mr Burgering raised no concerns in that regard.

[795] The evidence was that each of the applicants has, in fact, exercised his right to go to the MHRT on occasion. By way of example only:

(a) On 20 May 2004, the Tribunal found in respect of Mr M that:

> … it is necessary that the Applicant remain a special patient. Essentially, that is because whilst the Applicant's current condition is settled, he remains highly susceptible to becoming unsettled should the right circumstances not prevail and when he is unsettled he presents as a serious and immediate risk to the safety of others. In short, the protections to the public that special patient status affords are highly relevant in this case. It is also the Tribunal's view that special patient status continues to benefit the Applicant at this stage.

(b) On 23 November 2004, the Tribunal found in relation to Mr C that:

> As will be apparent from the narrative outlined previously in this decision there is more than sufficient evidence to persuade the Review Tribunal that [Mr C] is properly detained pursuant to a Compulsory Treatment Order.

(c) On 13 December 2005, the Tribunal noted in relation to Mr S that:

> [Mr S's] history of dangerousness has been documented elsewhere and will not be repeated on this occasion. Suffice to say that it is the view of the Tribunal that the Applicant's abnormal state of mind gives rise to serious dangerousness to the safety of others. In this regard, it is appropriate to take account of the Applicant's innate aggression. In other words, the Applicant's personality compounds the dangerousness which results from his illness. So too does the Applicant's intellectual disability compound the dangerousness, because the Applicant is less able to develop appropriate social responses when stressed.

[796] The Tribunal's 29 March 2007 decision in relation to Mr S is the subject of the seventh cause of action and has been discussed in more detail above.

[797] The applicants were present at the Tribunal hearing on all the above occasions and were always legally represented.[205] On most occasions they also had an advocate in attendance.

[798] There was also evidence about reviews conducted by the Family Court in respect of each applicant, in accordance with the legislation.

[799] Again, by way of example, an application to extend Mr M's compulsory care order was heard in the Family Court at Manukau in front of Judge Adams. Fourteen people made formal appearances at that hearing, including Paul Gruar as lawyer for Mr M, Asta Osbourne of the Justice Action Group, Mr Singh as Mr M's Support Person; and Mr M's Care Co-ordinator, his Care Manager, the Unit Manager, his Social Worker, a Psychiatrist and the District Inspector.

[800] Judge Adams noted out the outset "a couple of things that are very impressive" about the application process. Then he said:

> The other thing I want to say that is impressive is the depth of professional experience and wisdom that has been brought to bear in a mater like this. Looking around the room there is a body of professional fire power that is

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[205] Although in Mr C's case the Tribunal noted:

> It had been agreed at the teleconference held prior to the hearing, that in view of [Mr C's] disability and attention span, he would not be present during the course of the hearing. [Mr C] met with the Tribunal briefly and then happily went off to have lunch with the other patients in the unit.

> very significant and that makes me acknowledge that this matter is being treated seriously and I think very responsibly by the professionals involved.

[801] The Judge went on to note:

> Another thing that has not changed much is the risk assessment, which continues to be a high risk for dangerousness on recent presentation and that is the other area that the statute is mainly concerned about. Put starkly, it is [Mr M's] future against the risks to the community because discharge without changes in behaviour predictably mean that some member or members of the community will directly suffer.

[802] The Judge continued:

> I do feel considerably assisted by the depth of professionals who have participated in treatment, providing information and, in particular, those who have assessed. Also, of course, there is the typically thorough report of Dr Duff, which is expressed in sympathetic terms for [Mr M's] predicament but unflinchingly in terms of the statutory provisions.

[803] The Judge was "heartened that, despite the minimal changes that have been made, there is a rigorous professional hopefulness in the approach expressed through Ms McClintock's submissions for RIDCA and in Dr Duff's report". On that occasion, the Judge made a variety of recommendations and extended Mr M's compulsory care order for a period of 12 months.

[804] An example relating to Mr S involves a hearing at the Family Court in Wellington on 14 September 2007 in front of Judge Grace. Mr S was represented at the hearing by Mr Bott. Judge Grace found:

> [16] The evidence in this case satisfies me that [Mr S] does meet the criteria in that he does suffer from a disorder of cognition and that he does suffer from a disorder of volition and that it is intermitted and that it is of such a degree that it poses serious danger to the safety of others. It is therefore necessary to make a compulsory treatment order.
>
> [17] The next issue there is whether or not that order should be an inpatient order or a community treatment order. The Act makes it clear that the emphasis should be on a community treatment order unless the patient cannot be adequately treated within the community. The circumstances of this case make it abundantly clear in my view that Mr S cannot be adequately treated in the community. He has in the past been subject to orders making him a special patient. He has been discharged in the past, but there have been relapses and he has been readmitted to either the special patient status or has been detained in a hospital unit.

Failing to advise the applicants of their right to obtain a second opinion from a medical practitioner in respect of the medical assessment

[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 MHCAT and s 49 IDCCR. And as a matter of fact second opinions were sought on occasion.

Failing to review interrogation rules, instructions, methods and practices, and arrangements for the custody and treatment of Special Patients or Care Recipients, in breach of Article 11 CAT

[806] This pleading replicates the wording of Art. 11 of the Convention Against Torture, which provides that:

> 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.

[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.

Failing to give the applicants their NZBORA rights prior to undertaking any medical assessment which forms the basis of their continued detention

[808] This allegation is based on a misapprehension that is dealt with in more detail in the ninth cause of action. Put simply, the regular medical assessments and reviews have never formed the basis for the applicants' detentions and NZBORA rights are not therefore engaged. Without exception, they have been detained by order of the Court.

Failing to provide applicants with the right to be heard either in person, or through legal representation during the "proceedings" determining their continued detention

[809] This allegation is based on the same misapprehension as the previous one.

[810] To the extent that it can be seen as relating to legal representation in the Family Court (ie the place where orders about continued detention are actually made) the evidence was overwhelmingly that the applicants were not only legally represented but had numerous other support persons present. I have referred above to the number of people present on Mr M's behalf at a hearing in front of Judge Adams. And Dr Barry-Walsh gave evidence that he could not recall ever being involved in an application for a compulsory treatment order where the patient did not have legal representation. Moreover, he said:

> … if they didn't I would have been concerned and would have contacted the District Inspector and others to see whether we could facilitate that.

Failing to provide the applicants with legal representation in respect of the medical assessments

[811] This particular suffers from the same underlying misapprehension as the previous two.

Failing to provide the applicants with written and/or verbal reasons for their continued detention

[812] This contention is contradicted by the evidence which is that at the completion of each six monthly clinical review, Certificates of clinical review and assessment reports containing such reasons are provided both to the applicants and other specified persons in accordance with the requirements of the MHCAT Act and the IDCCR Act. The six monthly Certificates of clinical review identify the legal justification for a patient's continued detention and the assessments are discussed with patients by staff, by District Inspectors, and if they wish, their lawyers.

Failing to provide the applicants with the criteria for termination of their continued detention

[813] The starting point is that criteria justifying the applicants' continued detention are set out in the relevant statutes and relate risk and to public safety. The criteria are necessarily regularly addressed in the form of the six monthly certificates and reports just mentioned.

[814] At a more meaningful and concrete level, however, the criteria are addressed through the clinical assessments and the treatment plans developed for each patient which are discussed with them. The evidence reveals that staff talk continually with the applicants in order to develop and implement plans which address any barriers to less restrictive forms of detention. In that way each patient is made aware of the issues and behaviours he needs to address in order to be able to transition into the community, and is provided with tools to do so. This is most strikingly evident in Mr M's case, where he ultimately succeeded in meeting the relevant "criteria" and was discharged from compulsory care.

Failing to provide an effective and confidential complaints procedure

[815] I have spoken about the complaints procedures earlier in this judgment. No specific confidentiality issues have been raised. No concerns were expressed by Mr Burgering in this respect. The one specific allegation relating to Mr S's complaint about sexual abuse has already been addressed at length above.

[816] The evidence that was given by the respondents' witnesses about the complaints processes does not support the contention that the processes are not used, do not work or are not sufficiently independent.

[817] Again, by way of example only:

(a) Ms Daysh said of the CCDHB's process that:

> … part of what happens in orientation is that people are told that if they're not happy about something that they have the ability to make a complaint. We keep a record of complaints. So clients will fill this out but more often they'll sit with their care worker and have them

> help. Some of them have advocates who will sometimes come in and make them make a complaint about a particular aspect and then we have a log of all of the complaints made.

(b) In terms of the independence of the process, Ms Daysh continued:

> … each unit might manage this differently but if we just assumed for the sake of your argument that the person they wanted to complain about is their care worker, the person who works with them the most, then it is unlikely that they would say to the care worker. They would very likely say that to somebody else and that other person would independently engage in a process of investigating that. The person who they're complaining about would not be involved in that complaint process.

(c) Similarly, Dr Duff gave evidence about patients' understanding and use of the complaints process at Pōhutukawa Unit:

> The internal complaints process is very well known to all the service users and very well used by all of the service users. In the first instance – and there's also a poster on the wall that details the different pathways and steps for an internal complaint as well as an external complaint. So in the first instance we say – so on each shift there's a named member of staff assigned to each person on the unit. We say in the first instance raise it with the person who's assigned to you for the day. If you're not comfortable with them or you don't get the answer you want, raise it with the nurse in charge. If you don't get the answer you want or you're not satisfied with that, raise it to the unit manager or to the care manager or to the consultant. So that's the kind of pathway for raising complaints internally.

[818] Witnesses also gave evidence about the use of District Inspectors as a conduit for complaints (in accordance with their statutory functions). That evidence included that:

(a) Contact with a District Inspector is usually part of the admission process:

> … soon after their admission a District Inspector will come and introduce themselves. Rather than type their names, the clients themselves … will normally ask, "What's his phone number?"

(b) Ms Daysh gave evidence that:

> … District Inspectors are in facilities significantly more than twice a year. … not only are they there in their official capacity as District Inspector, but they are often more casually in services because they

> attend there for meetings. Clients know who their District Inspectors are and they'll certainly engage in conversations with them, casually or formally, but something that happens on a reasonably regular basis is that clients will ask to speak to the District Inspector and some clients are more self-advocates in this respect.

(c) Ms Daysh explained that the regular presence of District Inspectors at the Units was particularly valuable because it provided patients who might not actively seek to make a complaint or raise a concern with an opportunity to raise such matters on an ad hoc basis.

(d) Dr Duff spoke about the importance of District Inspectors and the Pōhutukawa Unit:

> … every care recipient is assigned a District Inspector. The list of contacts for the District Inspectors are displayed around the unit. Because of the nature of the quite restricted practices that we inevitably have at this level of this care and service, we are very conscious of the need to ensure that people do have easy access to District Inspectors for independent advice and support, to raise complaints, to externalise issues where they have concerns. So our District Inspectors will be very frequently contacted either by telephone or to come in to visit. They will often have consistency over a number of years with the District Inspector and will know them very well…

(e) In terms of day to day contact between patients and District Inspectors, Dr Duff said:

> Yes they do have a lot of contact with District Inspectors. It would be unusual for a week to go by without anybody having contact with the District Inspector from the unit, very unusual. Whether that's by telephone or, so the District Inspectors … would commonly come to review meetings or to visit pre-hearings or just to double check that there isn't anything that's happening. District Inspectors just being visible on the unit as well, we find is helpful because some people who might not think to make contact with the District Inspector, if one's walking through the unit quite a few people might then say, oh, well can I have a word as well and can I have a word as well so luckily we've had very good District Inspectors who have been prepared to not just wait until they're called but to be highly accessible and highly visible within the unit.

[819] It is also open to patients to access the Health and Disability Commissioner but it appears that none of the applicants has availed himself of those services.

Failing to provide procedural safeguards for the Applicants' liberty

[820] It is not entirely clear what is intended by this allegation. But to the extent it means that there are insufficient opportunities for reviewing whether the applicants should continue to be detained or that complaints procedures are inadequate I have dealt with it above. To the extent it is an attack on the statutes authorising their detention it is not clearly pleaded. Those statutes provide, in any event, a very large number of procedural safeguards.

Breach of Articles 12, 13, 14, and 15 of the Convention on the Rights of Persons with Disabilities

[821] The pleaded Articles are:

(a) Article 12 – equal recognition before the law;

(b) Article 13 – access to justice;

(c) Article 14 – liberty and security of person; and

(d) Article 15 – freedom from torture or cruel, inhuman or degrading treatment or punishment.

[822] All the issues raised by this pleading have been dealt with elsewhere in this judgment and I do not discuss them further.

Breach of Right 10 in the Code of Health and Disability Services Consumer Rights (Right to Complain)

[823] This has been dealt with above.

TWELFTH CAUSE OF ACTION – TOTALITY

[824] I have noted above that in *Taunoa* the Courts held that even in the absence of a finding that specific incidents or conduct constituted a breach of s 23(5) it was possible that a breach could be found when the totality of those incidents or conduct is considered. But that is not this case. I have found no breach of the law or of any

relevant standard. Indeed, in my view the three applicants have been treated with respect and as individuals throughout; each has had his own particular strengths, needs and difficulties recognised. While there have undoubtedly been improvements in the care they have received over the span of the claims, that is not because staff were delivering sub-standard care at the early stages. It is a function of the available facilities, changes in clinical thinking and, most of all, an ever-developing understanding of each of the applicants and how best to help them overcome the particular impediments they have faced.

[825] In my view this cause of action adds nothing to the earlier ones.

SUMMARY

[826] I summarize my findings in relation to the key aspects of the applicants' claims below.

Litigation guardian

[827] All aspects of the claim which purport to challenge the requirement in the High Court Rules for the applicants to have a litigation guardian are the subject of an earlier decision by Ronald Young J and are for that reason res judicata.

First, third and thirteenth causes of action – sexual assault of Mr S in 1999/2000

[828] Based on the District Inspector's findings at the time I accept that Mr S was assaulted by another patient (JC) on three occasions in late 1999 and early 2000. I am, however, unable to find that those assaults or the CCDHB's handling of them constitute a breach of the NZBORA. More particularly:

(a) there is no evidence that the DHB knew of, or were recklessly indifferent to, a serious and immediate risk to Mr S from JC and no basis for a finding that s 9 was breached;

(b) while, on the known facts, the s 23(5) protective duty owed to vulnerable detainees is engaged here, there is (15 years on) insufficient

evidence for me to form a view about whether the DHB breached that duty;

(c) once the assaults had been disclosed the DHB responded appropriately (by ensuring that JC and Mr S were kept apart and by notifying the District Inspector) and supported Mr S to make a decision about whether to go to the Police or to refer the matter to a District Inspector;

(d) the District Inspector also supported Mr S appropriately through that decision-making process;

(e) there is no evidence that any undue influence was brought to bear in the course of that process;

(f) there were, in any event, sound clinical reasons for not involving the Police or initiating a prosecution. In particular it is unlikely that a criminal prosecution would have been a beneficial process for Mr S or led to a more satisfactory resolution, given that JC would almost certainly have been found unfit to plead or stand trial; and

(g) the District Inspector's investigation was thorough, timely and impartial, and supported Mr S.

Fourth cause of action – rehabilitation

[829] I am of the view that:

(a) there has been no failure to provide the applicants with appropriate rehabilitative and therapeutic activities, let alone a failure that might constitute a breach of 23(5);

(b) there have been concerted and dedicated efforts to help the applicants move out of secure compulsory care. Those efforts are ongoing and have been successful in the case of Mr M and partly successful in relation to Mr S;

(c) there has been no denial of visits, telephone calls, correspondence or contact with advocates or lawyers, except temporarily and where clinically justified; and

(d) the decisions to cancel leave following Mr M's AWOLs were not in breach of s 25(3) or made to punish him. Rather they were rational and necessary responses to the risk he posed and reflective of the WDHB's legal obligations at the time.

Fifth cause of action – sexual relationships

[830] No breach of ss 9 or 23(5) is established in relation to sexual matters. More particularly I find:

(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;

(c) sex and relationship education is offered in the Units when considered clinically necessary and wider education about relationships and appropriate physical interactions also forms part of 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. While masturbation may, on occasion, 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) the right to freedom of expression protected by s 14 of the NZBORA the removal was demonstrably justified.

Sixth cause of action – seclusion and restraint

[831] No breach of ss 9 or 23(5) has been established in relation to the use of seclusion and restraint:

(a) seclusion and restraint is not used as punishment but in response to a real and immediate risk posed to the safety of the patients themselves and to others;

(b) the risk of violence that has been posed from time to time by each of the applicants is real and significant. Indeed it is that risk which is the cause of their continued detention;

(c) although there are rare occasions which, in retrospect, staff have accepted could have been managed better, not one of the documented instances of seclusion and restraint has been shown to be unlawful or not warranted in terms of risk;

(d) there are numerous standards, guidelines and policies that regulate the use of seclusion and restraint and which emphasise minimisation of those practices. Staff are trained in accordance with those guidelines and in the safe use of restraint and seclusion;

(e) behavioural strategies have been put in place specifically to minimise and manage the risk of violence from the applicants and (therefore) the need for their restraint and seclusion. The evidence was that these strategies have in fact decreased that need;

(f) record-keeping requirements provide for a high level of transparency in the use of restraint and seclusion, and allow for strict monitoring, both by external agencies, and by internal DHB bodies set up to implement strategies to reduce the incidence of restraint and seclusion;

(g) there was no evidence supporting any suggested use of chemical restraint;

(h) night safety procedures are put in place for sound operational (risk) reasons, although Ministry guidance on its use has, from time to time, been inconsistent and confusing;

(i) the absence of seclusion guidelines under s 148(2) of the IDCCR Act does not make the use of seclusion under s 60 of that Act unlawful, provided that it meets the criteria for initiation and termination set out in that section;

(j) seclusion under s 60 does not, in any event, arise on the facts of this case because only Mr M has ever been subject to the IDCCR Act and he was not secluded pursuant to it;

(k) procedures and polices ensuring safety during seclusion, which reflect and expand on the guidance issued for MHCAT Act seclusion, were in place at each DHB at all times;

(l) there is no discernible legal difficulty with the Ministry's 1992 Guidelines for the Use of Seclusion; and

(m) the required four yearly reviews of the HDSSA standards on seclusion and restraint have, in fact, occurred.

Sixth cause of action – Mr S' correspondence

[832] In my view:

(a) s 17 of the NZBORA (freedom of association) is not engaged by any restrictions on writing letters; and

(b) s 14 of the NZBORA does not require staff to take dictation from a patient and, in any event, the letter that Mr S wished to write to the Leader of the Opposition was in fact written and sent.

Seventh cause of action – MHRT decision

[833] The impugned MHRT decision does not evidence predetermination in any material sense. There were other avenues of redress available to Mr S.

Eighth cause of action – living conditions at "Porirua Hospital"

[834] No breach of s 23(5) is established. In particular:

(a) the applicants did not call any evidence of their own in support of the specific allegations made in the eighth cause of action;

(b) in terms of the physical environment at Haumietiketike, the regular audits, and oversight by the Ombudsman, provides assurance that standards are being met. That was confirmed by the Court's own view of the Unit; and

(c) any limited intrusions on the applicants' privacy, restrictions on personal belongings or access to sanitary facilities have been clinically justified and were relatively minor.

Ninth cause of action - discrimination and arbitrary detention

[835] The discrimination claim is not made out. In particular:

(a) the proposition that the CPMIP Act "diversion" regime contravenes s 19 of the NZBORA was not properly argued;

(b) in any event:

(i) "ordinary" prisoners are not the relevant comparator group;

(ii) the reason for the difference in treatment received by the applicants is not the prohibited ground of intellectual disability, but risk;

(iii) the regime benefits rather than prejudices those such as the applicants; and

(c) to the extent that the discrimination claim seeks to impugn acts done pursuant to and in accordance with the CPMIP Act (or the MHCAT Act) those acts were authorised by law and cannot be found to be discriminatory.

[836] Nor do I consider that the claims of arbitrary detention are made out:

(a) the detention of the applicants has at all times been authorised by statute and/or by the Courts. There is no basis for allegations of "executive" detention;

(b) there is a thorough and mandatory system for regularly reviewing the need for their continued detention;

(c) the basis for the applicants' continued detention has in fact been regularly and systematically reviewed; and

(d) the applicants have extensive rights of review and appeal in relation to the outcomes of those reviews, which they have in fact exercised from time to time.

Tenth cause of action – medical care and consent

[837] There was no evidence to support the allegation that there has been inadequate provision of medical care to the applicants, let alone an inadequacy of such magnitude that s 23(5) has been breached. The example of a single medical error (when the wrong medication was administered to Mr C) was an isolated incident which was properly managed with no ill effects. And although it took some time to resolve all of Mr C's

dental issues there were many unavoidable reasons for those delays, including the need to obtain a Court order and Mr C's own fear of dental appointments.

[838] In terms of consent to medical treatment under s 11 of the NZBORA:

(a) the relevant clinicians were well aware of the fluctuating levels of the applicants' capacity to consent and have acted accordingly;

(b) the applicants were always involved in decisions about their medical treatment regardless of their formal capacity to consent; and

(c) while on occasion treatment has been provided without consent, that has only ever been in emergency situations as authorised by statute.

Eleventh cause of action - periodic reviews

[839] In summary:

(a) there is no evidence of any failure regularly and periodically to review the applicants' continued detention as required by law;

(b) oversight of their detention by the Courts has also been in accordance with the legislation;

(c) the allegation that there has been a failure to give the applicants their rights under NZBORA prior to undertaking, or to afford them the right to be legally represented at, any periodic medical review is based on a misunderstanding about the basis of their continued detention;

(d) The applicants' continued detention is authorised by way of judicial process and they have, and have routinely exercised, such rights in that context;

(e) there has been no failure to provide the applicants with the reasons for their continued detention and no evidence that the clear statutory requirements in that regard have not been met;

(f) there is no evidence that the applicants have not been told or do not understand what must occur in order for them to be released from secure compulsory care; and

(g) there are effective and confidential complaints procedures in place which are, in fact utilised.

Twelfth cause of action – totality

[840] There is no evidentiary basis for a finding of breach of either ss 9 or 23(5) on a totality basis.

CONCLUDING REMARKS

[841] The short and more general point is that the three applicants have, throughout their time in compulsory care, received dedicated and compassionate care from dedicated and compassionate staff. It is accepted that, on occasion, certain things could have been done better. But the very real, albeit slow, progress made by each of the applicants, in his own way, speaks for itself.

[842] So it is, I think, important to record that I remain entirely unpersuaded that any one of the staff members who has cared for these three men over the years has ever been motivated by anything other than the men's best interests. I have not before come across such a devoted group of medical professionals, committed to caring for, and improving the lives of those such as the applicants, often under difficult and dangerous circumstances.

[843] The claims are dismissed, for the reasons I have given.

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Rebecca Ellis J