ORDER: NONE OF THE NAMES OF OR OTHER IDENTIFYING INFORMATION ABOUT THE PARTIES (OTHER THAN THE CROWN HEALTH FINANCING AGENCY) OR ANY PERSONS NAMED IN ANY DOCUMENTS FILED IN THESE APPEALS ARE TO BE PUBLISHED IN ANY MEDIA REPORTS OR IN PUBLICLY AVAILABLE DATABASES.

IN THE SUPREME COURT OF NEW ZEALAND

SC 72/2008
[2009] NZSC 97

BETWEEN	B AND OTHERS Appellants
AND	CROWN HEALTH FINANCING AGENCY Respondent

Hearing: 2 April 2009

Court: Elias CJ, Blanchard, Tipping, McGrath and Wilson JJ

Counsel: S M Cooper and K Ross for Appellants
D B Collins QC Solicitor-General, U Jagose and L Hansen for Respondent
R Chapman as Amicus Curiae

Judgment: 17 September 2009

JUDGMENT OF THE COURT

A **The appeal is allowed to the extent indicated in paragraph [75].**

B **The proceedings that were before the Court of Appeal are remitted to the High Court for resolution in accordance with the decision of this Court.**

C **The appellants are entitled to costs in the sum of $15,000 together with reasonable disbursements to be fixed if necessary by the Registrar.**

D Suppression orders made in the Court of Appeal and High Court are to continue.

REASONS

(Given by McGrath J)

Table of Contents **Para No**

Introduction

[1] During the 1970s each of the six appellants spent a period or periods as a patient admitted to Porirua Psychiatric Hospital. On some occasions the appellants were admitted with their agreement, under procedures that did not involve the formalities required for committed patients. At other times the appellants were patients who had been committed under the requirements of the legislative regime applying at the time.

[2] The appellants allege that while they were inpatients who had agreed to be admitted, they were mistreated by hospital staff. They allege acts by hospital staff involving physical assaults and sexual abuse, failures by the authorities to protect them from other patients, inappropriate use of electro-convulsive therapy and subjecting them to long periods of solitary confinement as punishment. Each has brought proceedings against the public agency which is successor to the liabilities of

the Crown and the Hospital Board which at the relevant times operated the psychiatric hospital concerned. They claim general and exemplary damages.

[3] Mental health legislation, at the relevant times, imposed procedural and substantive requirements for the bringing of civil or criminal proceedings arising out of acts done pursuant to it. No one was liable for such acts in civil or criminal proceedings, unless they had acted in bad faith or without reasonable care. Plaintiffs also had to obtain the leave of the court to bring such proceedings, which was not to be given unless a substantial ground was shown for the contention that the person had acted in bad faith or without reasonable care. As well, the application for leave had to be made within six months of the alleged act.

[4] It is clear that these requirements for initiating court proceedings at all relevant times applied to acts done by hospital staff to patients admitted and treated under the legislation as committed patients. The issue in the appeal, which arises in the context of an application by the respondent to strike out the appellants' claims, concerns whether the requirements also applied to proceedings arising out of acts done to patients admitted for treatment informally. We refer to them throughout this judgment as "informal patients" although that term did not enter the legislation until 1969. Addressing this question involves the interpretation of different applicable provisions in New Zealand mental health legislation over the years.

[5] We have been informed by counsel that some 280 persons who were informal patients in New Zealand psychiatric hospitals during the 1960s and 1970s have brought or intend to bring proceedings alleging that they were mistreated in like circumstances to those alleged by the appellants. The outcome of this appeal is seen as likely to determine the future course of those proceedings. The appellants' claims, and that of another separately represented former patient, have been treated as test cases in the sense that legal advisers anticipate that the issues determined in relation to them would substantially assist resolution of like issues in the remaining cases.

Mental health legislation concerning informal patients

[6] Before setting out the statutory provisions that impose the requirements for bringing proceedings, it is helpful to refer to the historical context of mental health legislation in New Zealand concerning admission and treatment of patients who entered psychiatric hospitals voluntarily rather than as committed patients.

[7] Prior to 1911 it was unlawful in New Zealand for those in charge to receive any person into a psychiatric hospital for treatment without a court order. It was also unlawful to permit persons to remain in the hospital after expiry of an order without appropriate certificates.[1] The Mental Health Act 1911[2] made it lawful for the medical officer of an institution to "admit and detain any person … in that institution for care and treatment as a voluntary boarder", if the person signed a written request, acknowledging he or she was liable to be detained in the institution for up to seven days after applying to be discharged.[3] Where the mental condition of a voluntary boarder made it improper for that person to remain in the hospital under that status, the 1911 Act provided that the medical officer should make an application to commit the person.[4]

[8] In 1961 the provisions in the 1911 Act dealing with admission of voluntary boarders were repealed and replaced.[5] The category of patients known as voluntary boarders was renamed "voluntary inpatients".[6] They continued to be admitted on their written request made in a prescribed form. Voluntary inpatients could be detained for up to 24 hours after giving notice of intent to leave the institution and a further four days if an application for a reception order was made.[7] The 1961

---

1 Section 15 of the Lunatics Act 1866; s 27 of the Lunatics Act 1882 and s 22 of the Lunatics Act 1908.

2 The 1911 Act was originally titled the Mental Defectives Act 1911. The short title was amended in 1950 to become the Mental Health Act 1911: s 2 of the Mental Health Amendment Act 1954.

3 Section 39(1).

4 Section 39(2) and (6).

5 By s 3 of the Mental Health Amendment Act 1961.

6 Section 3(1)(a).

7 As part of the procedure for admission as a committed patient. Section 3(3) of the Mental Health Amendment Act 1961.

legislation also made provision for the first time for patients who did not have capacity to consent to be admitted informally on the application of another person.[8]

[9] This policy of minimising formality in admission procedures for patients was taken a step further in Part 2 of the Mental Health Act 1969 which was headed "Informal Patients". Distinctions between categories of informal patients were abolished. As well, specified forms for the consent of the patient or application by another person were no longer required for admission as an informal patient.[9] Admission did not automatically result in any statutory liability to be detained but if the patient gave notice of intention to leave the superintendent could apply to a District Court Judge for a reception order. Making that application conferred authority to detain the person until the application was determined.[10]

[10] Another important change in the 1969 Act was its provision that psychiatric hospitals could be carried on by hospital boards under the Hospitals Act 1957, as well as by the Crown. To this end the Minister of Health was given the power to transfer psychiatric hospitals to hospital boards.[11] Following such a transfer the hospital board was required to proceed to carry on that hospital.[12] The 1969 Act stipulated that the provisions in Part 2 in relation to informal patients did not apply to hospitals that were carried on by hospital boards. Nor did that Act apply to persons admitted to those hospitals.[13]

[11] Control of psychiatric hospitals was transferred to hospital boards under the statutory powers in 1972. Prior to the transfers taking effect, the 1969 Act was amended, stipulating that the provisions in Part 2 in relation to informal patients did not "limit or affect the discretion of a Hospital Board to admit any person to a hospital carried on by it".[14]

---

8 Sections 5 and 6 of the Mental Health Amendment Act 1961.
9 Section 15 of the Mental Health Act 1969.
10 Section 16 of the 1969 Act.
11 Section 7(1) and (2) of the 1969 Act.
12 Section 7(3) of the 1969 Act.
13 Section 14. The Explanatory Note to cl 14 of the Mental Health Bill (1968), p vii said that the reason was that hospital boards had sufficient authority under the Hospitals Act 1957 to admit patients to institutions without formality.
14 Section 18A(3).

[12] The term "informal patients" ceased to appear in mental health legislation with the enactment of the Mental Health Act 1992. The focus of that Act is on providing for compulsory treatment of those with mental disorders who are unable or unwilling to consent to treatment.

[13] Provisions in mental health legislation over the years both in New Zealand and the United Kingdom have imposed procedural and substantive requirements before legal proceedings could be brought by psychiatric hospital patients.[15] In the 1911 Act s 131(1) provided that "[a] person who does any act in pursuance or intended pursuance of any of the provisions of this Act" was not under any civil or criminal liability "if he has acted in good faith and with reasonable care". The court was given power to stay proceedings brought in respect of any such act if satisfied that there was no reasonable ground for alleging want of good faith or reasonable care or that the proceedings were frivolous or vexatious.[16] As well, a six months limitation period for bringing such actions was imposed.[17]

[14] In 1935 an amendment to the 1911 Act repealed the stay provision.[18] In its place s 6 of the Mental Health Amendment Act 1935 imposed a requirement that leave be obtained before any person commenced such a proceeding. Thereafter a patient wishing to bring a proceeding against a person who was acting under mental health legislation first had to satisfy a judge that there was substantial ground for the contentions made before being able to commence proceedings. Section 6 continued to apply until repeal of the 1911 Act in 1969. It was replaced by s 124 of the 1969 Act which, as described below, is in substantially the same terms.

---

15 Provision was made in s 12 of the Lunacy Acts Amendment Act 1889 (UK) for proceedings against staff to be stayed on application to the High Court if the Court were satisfied there were no reasonable grounds for alleging want of good faith or reasonable care.

16 Section 131(3).

17 Section 131(4).

18 Section 6 of the Mental Health Amendment Act 1935.

Procedural background

[15] The application to strike out the claims for failure to comply with the procedural requirements to bring the proceedings first came before Associate Judge Abbott who held that ss 6 of the 1935 Act and 124 of the 1969 Act did not apply because treatment and care of informal patients was by private arrangement and discretionary. It was not done pursuant to the mental health legislation.[19]

[16] On review of that decision Simon France J disagreed with the Associate Judge.[20] Simon France J held that treatment, care and control of those admitted to psychiatric hospitals as informal patients was successively authorised by s 39 of the 1911 Act, s 3 of the 1961 amendment to that Act, and s 15 of the 1969 Act while each applied. The Judge also decided that the last of those provisions ceased to apply to informally admitted patients of those hospitals which came under hospital board control on 1 April 1972, with the result that the statutory protection given to doctors and staff since 1935 by ss 6 and 124 then ceased to apply.[21]

[17] The Court of Appeal upheld Simon France J insofar as he decided that the protection applied until 1972 but rejected his conclusion that it ceased to apply thereafter.[22] The Court concluded that acts of care, treatment and control of informal patients in hospitals under hospital board control continued to be in pursuance of the 1969 Act for the purposes of s 124. The Court of Appeal relied on various provisions in the 1969 Act that continued to apply in respect of such patients and said:[23]

> If the intention had been to remove the protection of s 124 in respect of similarly situated informal patients after 1 April 1972 the [1969 Act] would surely have been expressly amended to make this clear.

---

19 *P v Residual Health Management Unit* (High Court, CIV 2003-485-1625, 23 June 2006, Associate Judge Abbott) at para [63].

20 *P v Crown Health Funding Agency* (High Court, CIV 2003-485-1625, 19 December 2006, Simon France J).

21 At para [89].

22 *Crown Health Financing Agency v P* [2009] 2 NZLR 149 at paras [130] – [149] per Hammond J.

23 At para [143] per Hammond J.

[18] The Court of Appeal accordingly held that the appellants were at all relevant times subject to the procedural restrictions on their right to bring proceedings arising out of acts that took place during periods when they were informally admitted patients at the hospital. The Court referred the proceedings back to the High Court, so that the question of whether requirements for leave to bring the proceedings applied to the particular circumstances alleged by each appellant would be dealt with as a preliminary issue.

[19] This Court has given leave to appeal against the Court of Appeal judgment. The issues for determination are, first, whether s 6 of the 1935 amending Act and s 124 of the 1969 Act applied to patients who were informally admitted to psychiatric hospitals while they were controlled by the Crown and if so, secondly, whether s 124 applied to those patients who remained in or were admitted to hospitals, controlled by a hospital board after 1 April 1972.

[20] These issues require us to clarify the meaning of provisions in mental health legislation in two respects. We must first address the meaning of the provisions giving protection to those who acted pursuant to legislation. Secondly, we must clarify the meaning of the legislation pursuant to which the respondent contends acts alleged would have been taken. This will establish principles for deciding whether protection will apply in individual cases. We are not, however, required or able in this appeal to decide whether protection actually applies in respect of particular actions alleged in the proceedings. To the extent that the nature of what is alleged to have taken place may fall outside of acts qualifying for protection, that will be for the High Court to decide according to the circumstances in individual cases.

[21] Another person who had also been a respondent in the Court of Appeal was also given leave to appeal to this Court but decided to withdraw his appeal shortly before the hearing. In the special circumstances of this case we appointed his counsel, Mr Chapman, as an amicus, and he has made submissions to us which were supportive of the appellants' position.

Applicable statutory provisions

[22] It is convenient first to set out the provision inserted in the 1911 Act by the Mental Health Amendment Act 1935 which imposed procedural and substantive requirements for proceedings that applied until 31 March 1970 when it was repealed and replaced by the Mental Health Act 1969:

> **6** (1) A person who does any act in pursuance or intended pursuance of any of the provisions of the principal Act shall not be under any civil or criminal liability in respect thereof, whether on the ground of want of jurisdiction, or mistake of law or fact, or any other ground, unless he has acted in bad faith or without reasonable care.
>
> (2) No proceedings, civil or criminal, shall be brought against any person in any Court in respect of any such act except by leave of a Judge of the [High Court], and such leave shall not be given unless the Judge is satisfied that there is substantial ground for the contention that the person against whom it is sought to bring the proceedings has acted in bad faith or without reasonable care.
>
> (3) …
>
> (4) Leave to bring such proceedings shall not be granted unless application for such leave is made within six months after the act complained of, or, in the case of a continuance of injury or damage, within six months after the ceasing of such injury or damage:
>
> Provided that in estimating the said period of six months no account shall be taken of any time or times during which the person injured was in confinement, whether lawfully or unlawfully, as a mentally defective person, or was ignorant of the facts which constitute the cause of action, or of any time or times during which the defendant was out of New Zealand.

[23] The equivalent provision conferring protection in the 1969 Act with effect from 1 April 1970 was s 124. It was expressed in terms similar to the 1935 provision although conferring protection on the Crown as well as the person whose act gave rise to the intended litigation. None of the differences in expression of s 124 from its predecessor are material to the issues in the appeal. In particular the key phrase in the 1935 provision, "in pursuance or intended pursuance of any of the

provisions of the Act", is for practical purposes the same as that used in the 1969 Act,[24] s 124 of which provided:

> **124 Protection of persons acting under authority of Act—**
>
> (1) Neither the Crown nor any person who does any act in pursuance or intended pursuance of any of the provisions of this Act shall be under any civil or criminal liability in respect of any such act, whether on the ground of want of jurisdiction, or mistake of law or fact, or any other ground, unless the person has acted in bad faith or without reasonable care.
>
> (2) No proceedings, civil or criminal, shall be brought against the Crown or any person in any Court in respect of any such act except by leave of a Judge of the [High Court]. Such leave shall not be given unless the Judge is satisfied that there is substantial ground for the contention that the person in respect of whose act or omission it is sought to bring the proceedings has acted in bad faith or without reasonable care.
>
> (3) …
>
> (4) Leave to bring such proceedings shall not be granted unless application for such leave is made within six months after the act complained of, or, in the case of a continuance of injury or damage, within six months after the ceasing of such injury or damage:
>
> Provided that in estimating the said period of six months no account shall be taken of any time or times during which the person injured was detained, whether lawfully or unlawfully, as a mentally disordered person, or was ignorant of the facts that constitute the cause of action, or of any time or times during which any defendant was out of New Zealand.

[24] The restrictions on bringing proceedings contained in the 1935 and 1969 Acts were in respect of acts done in pursuance or intended pursuance of the mental health legislation. The provisions of that legislation differed over three periods of time relevant to the appellants and other litigants. During the first period, from 1 January 1962 until 31 March 1970, the relevant provision in relation to informally admitted patients was s 3 of the Mental Health Amendment Act 1961:

> **3 Admission or enrolment of voluntary inpatients or outpatients**
>
> (1) Notwithstanding anything in the principal Act, it shall be lawful for the Superintendent of any institution, on a request made in the prescribed form by any person who is not less than sixteen years of

[24] The 1935 Amendment Act referred to "any of the provisions of the *principal* Act …", that being the Mental Health Act 1911.

age, and who in the opinion of the Superintendent is able to understand the nature and effect of the request,—

(a) To admit that person to the institution for care and treatment as a voluntary inpatient; or

(b) To enrol him as a voluntary outpatient of the institution and from time to time to provide treatment for him there as an outpatient.

(2) The Superintendent shall not have power to detain any voluntary outpatient.

(3) A voluntary inpatient is not liable to be detained in the institution; except that he may be so detained—

(a) For a period not exceeding twenty-four hours after the receipt by the Superintendent of a notification in writing from the inpatient of his intention to leave the institution; or

(b) In any case where the Superintendent forms an opinion under subsection (5) of this section, for a period not exceeding four days after the dispatch of the communication referred to in that subsection; and

(c) In any case where an application for a reception order is made in respect of the inpatient, until the application is finally determined.

…

[25] As well, the 1961 amendment provided for the first time for informal admission of two categories of patients who lacked capacity for consent to treatment. Section 5 related to "mentally infirm" persons:[25]

5 Admission of mentally infirm persons—

(1) Notwithstanding anything in the principal Act, any person who is not less than twenty-one years of age may apply to the Superintendent of any institution in the prescribed form for the admission of any mentally infirm person to the institution for care and treatment.

(2) The application shall be accompanied by a recommendation in the prescribed form signed by a medical practitioner and bearing a date not earlier than seven days before the date of the application.

(3) On receipt of the application and recommendation the Superintendent may, if he thinks fit, admit the mentally infirm person to the institution for care and treatment.

---

[25] Primarily being elderly persons with mental deterioration which would worsen without treatment.

[26] Section 6 related to those classed as "mentally subnormal":[26]

> **6 Admission of mentally subnormal persons—**
>
> (1) Notwithstanding anything in the principal Act, any parent or guardian, or any person not less than twenty-one years of age who has been acting in the place of a parent, of any mentally subnormal person (whether or not the mentally subnormal person is under the age of twenty-one years) may apply to the Superintendent of any institution in the prescribed form for the admission of that person to the institution for care, treatment, training, and occupation.
>
> (2) The application shall be accompanied by a recommendation in the prescribed form signed by a medical practitioner and bearing a date not earlier than seven days before the date of the application.
>
> (3) On receipt of the application and recommendation the Superintendent may, if he thinks fit, admit the mentally subnormal person to the institution for care, treatment, training, and occupation.

[27] Patients admitted informally under ss 5 and 6 were not liable to be detained other than in specified circumstances of necessity including where they were the subject of an application for a reception order.

[28] The second period commenced with the coming into effect of the 1969 Act on 1 April 1970 and ran until 31 March 1972. The event which ended the second period was the transfer of control of psychiatric hospitals from the Crown to hospital boards. This was authorised by the 1969 Act but not put into effect by the Minister until 1 April 1972.

[29] The relevant provisions in relation to the second period are, first, the definition of informal patients under the 1969 Act:[27]

> "Informal patient" means a person, not being a committed patient or a special patient, who is receiving care and treatment in a psychiatric hospital carried on by the Crown or in a licensed institution, having been admitted thereto under Part II of this Act.

[30] Secondly, provisions in Part 2 of the 1969 Act, headed "Informal Patients" are in point. At the time that Act came into effect the provisions in Part 2 relevant to the second period read:

---

[26] Being persons suffering mental illness of moderate severity within certain of the classes of "mentally defective persons" under the 1911 Act.

[27] Section 2.

14 Application of this Part—

Nothing in this Part of this Act shall apply to hospitals carried on by Hospital Boards or to persons admitted thereto.

15 Treatment of outpatients and admission of informal patients—

(1) The superintendent of a hospital may in his discretion, pursuant to any arrangements made with him in respect of any person who in his opinion would benefit from psychiatric care and treatment, whether or not he is mentally disordered within the meaning of this Act,—

(a) Treat that person without admitting him to the hospital; or

(b) Admit him to the hospital for treatment without any reception order or request that would render him liable to be detained under this Act; or

(c) Permit him to remain in the hospital for treatment after he has ceased to be liable to be detained in the hospital.

…

16 Superintendent may apply for reception order—

(1) The superintendent of a hospital may at any time, in his discretion, apply pursuant to section 21 of this Act for a reception order in respect of any person who has been admitted to the hospital under this Part of this Act, whether or not the person is within the hospital when the application is made:

Provided that if the person is not within the hospital, whether his absence is intended to be temporary or permanent, an application under this subsection shall not be made more than seventy-two hours after he left the hospital.

(2) The fact that an application for a reception order in respect of any person admitted under this Part of this Act has been forwarded to the Registrar shall be sufficient authority for the superintendent to detain the person (if he is within the hospital) until the application is finally determined.

…

[31] The third period commenced on 1 April 1972 and ran until the 1992 Act repealed the 1969 Act. In relation to the third period, the provision in the 1969 Act which authorised the transfer of hospitals, in its original form, read:

7 Management of psychiatric hospitals and services—

(1) Subject to this Act, a psychiatric hospital may be carried on by the Crown, through the Division of Mental Health of the Department of

Health, or by a Hospital Board in accordance with the Hospitals Act 1957.

(2) The Minister may, with the consent of a Hospital Board, transfer to that Board the control of any psychiatric hospital carried on by the Crown, and may vest in or transfer to that Board any land, buildings, equipment, and other property vested in or belonging to the Crown in connection with or used for the purposes of that hospital.

…

(3) On the transfer of a hospital to the control of a Hospital Board pursuant to subsection (2) of this section, the Board shall proceed to carry on that hospital, and, except as may otherwise be agreed between the Minister and the Board, all the contracts, debts, and liabilities of the Crown relating to that hospital shall become the contracts, debts, and liabilities of the Board.

…

[32] Section 14, already referred to, is also relevant in relation to the third period. It was amended with effect from 1 April 1972,[28] to read:

14 Application of this Part—

Except as provided in section 18A of this Act nothing in this Part of this Act shall apply to hospitals carried on by Hospital Boards or to persons admitted thereto.

And s 18A itself provided:[29]

18A Application of Part II of principal Act to hospitals carried on by Hospital Boards—

(1) Section 16 of this Act shall apply in respect of any person, not being a special patient or a committed patient, who is for the time being maintained for the purpose of treatment in a psychiatric hospital carried on by a Hospital Board, as it applies in respect of a person who is for the time being maintained in a hospital carried on by the Crown, having been admitted thereto under this Part of this Act.

(2) Notwithstanding the transfer of the control of a hospital to a Hospital Board pursuant to subsection (2) of section 7 of this Act, subsection (2) of section 17 of this Act shall continue to apply in respect of the estate of any person maintained in the hospital if that subsection applied to that estate immediately before that transfer.

---

28 By s 3(2) of the Mental Health Amendment Act 1972.

29 Section 18A was inserted in this form by s 3(1) of the Mental Health Amendment Act 1972 with effect from 1 April 1972.

(3) Nothing in section 14, section 15, or section 18 of this Act shall limit or affect the discretion of a Hospital Board to admit any person to a hospital carried on by it.

The English position

[33] The appellants rely on English authority in support of their submission that patients who were informally admitted during each of the three periods were not admitted or treated under the applicable legislation. In *R v Runighian*,[30] the appellant, an employee of a psychiatric hospital, who had been charged with assault of an informal patient, applied to quash the count on the ground that leave of the High Court had not been obtained in terms of the Act[31] before the proceeding was brought. The Crown Court dismissed the application on the ground that "acts done to such persons were not done in pursuance of the Mental Health Act or any of the relevant rules or enactments set out in s 141".[32] Rather, in a permissive section, the Act had merely authorised their admission by private arrangement for treatment. Acts done following their admission under such arrangements accordingly fell outside of the Act's protective provisions.

[34] Earlier, in *Pountney v Griffiths*,[33] the House of Lords had held that the ambit of the procedural protection for acts taken pursuant to the English legislation extended to acts done by the staff of psychiatric hospitals in discharging day to day duties in the control or purported control of patients.[34] Protection was not confined to acts directly associated with certification and reception of patients under the Act. The Court in *Runighian* distinguished *Pountney v Griffiths* on the basis that the House of Lords' judgment had involved a committed patient.

[35] No subsequent English decision addresses the reasoning in *Runighian* but Professor Dimond gives the decision some qualified support.[35] While

---

30 [1977] Crim LR 361.

31 Section 141(1) of the Mental Health Act 1959 (UK) provided protection for acts done in pursuance of the Mental Health Act 1959. Subsection (2) provided that no civil or criminal proceedings shall be brought without leave of the High Court.

32 At p 362.

33 [1976] AC 314 (CA and HL), sometimes cited as *R v Bracknell Justices, ex p Griffiths*.

34 At pp 332 and 336 per Lord Edmund-Davies.

35 Dimond, "Staff Protection Against Civil and Criminal Action Under the Mental Health Act 1983" (1987) 11 Bulletin of the Royal College of Psychiatrists 333, pp 334 – 335.

acknowledging that it is arguable, despite the reference in the English provision concerning admissions, that an informal patient is in hospital by virtue of an act purporting to be done in pursuance of the Act, she suggests that "is probably too wide an interpretation" of the immunity provision.

[36] In *R v Bournewood Community and Mental Health NHS Trust; ex p L*,[36] a majority in the House of Lords decided that the basis of the detention of patients who were unable to give an effective consent to their admission, and had been admitted under s 131(1) of the Mental Health Act 1983 (UK) without resistance, was the common law of necessity.[37] Lord Goff, with whom Lord Lloyd and Lord Hope agreed, concluded that this common law principle was the basis on which informal patients, who were incapacitated in this sense, were restrained.[38] Lord Goff did, however, also acknowledge that "[i]t might … be possible to discover an implication in the statute providing similar justification …".[39] Lord Steyn decided that, as a matter of statutory construction against the context of the principles of the common law, s 131 permitted admission of a compliant incapacitated patient where requirements of the principle of necessity were satisfied.[40] The case accordingly is not a strong authority for the proposition that informal patients in England have been admitted and treated under common law rather than statutory powers.

[37] As well, s 131 of the 1983 United Kingdom Act was in the same terms as s 5 of the Mental Health Act 1959 (UK). The 1959 Act had been based on the Report of a Royal Commission in 1957 which favoured reducing use of compulsory powers of admission of all mentally disordered patients to a minimum and admitting them to hospital and treating them "on the same basis as other sick or handicapped persons without certification".[41] The Royal Commission had proposed that the legislation should abandon the assumption that compulsory powers had to be used unless a positive consent to admission and treatment was given by a person. Hospitals were to offer treatment and care to all those who would benefit from them and who were

---

36 [1999] 1 AC 458.
37 At pp 485 – 486, 489 – 490, and 497.
38 At pp 485 – 486 and 489.
39 At pp 485 – 486.
40 At pp 495 – 497.
41 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954 – 1957 UK Cmnd 169 (1957), paras [282] – [283], [287] – [291] and [297] – [300].

not themselves or through their relatives positively objecting to admission and treatment.[42] The effect of the judgment in *Bournewood* was to confirm that two groups of patients entering psychiatric hospitals, that is those who, having capacity to do so**,** volunteered and those who were incapacitated but not resisting, were able to be admitted informally.[43]

[38] New Zealand, however, retained in its legislation the requirement of a valid consent or an application in prescribed form by another person as the basis for admission of all informal patients until the 1969 Act provided otherwise. The difference in the legislation in effect concerning informal patients in the two jurisdictions from 1959 to 1972 means that the English decisions are of limited assistance in deciding what was authorised by the New Zealand mental health legislation, and what was authorised by the common law, during that period.

Submissions of parties

[39] Ms Cooper's argument, for the appellants, in relation to each of the three periods, was that the admission and treatment of those patients whose admission was informal was not under statutory authority. Such authority extended only to those who were committed patients. In respect of the first period (1 January 1962 until 31 March 1970) admission and treatment of voluntary inpatients was allowed, but only in the sense that it was not prohibited by the 1961 Act. This, according to counsel, reflected the context of the previous position under the 1911 Act which had removed earlier prohibitions on admission and treatment of persons who were not committed patients. Authority to admit and treat such people was, counsel argued, by agreement between the hospital superintendent and the person who became a "voluntary patient" and not in pursuance of or intended pursuance of the Act. Counsel submitted that the protection given by s 6 of the 1935 amendment to the 1911 Act was accordingly not available for the first period.

---

42 At paras [7], [41] – [42], [288] and [291].

43 See Fennell, "Doctor Knows Best? Therapeutic Detention Under Common Law, the Mental Health Act and the European Convention" [1998] Med L Rev 322, pp 330 – 332.

[40] The appellants' argument in relation to the second period was that the admission and treatment of informal patients under the 1969 Act was explicitly a matter for arrangements made by the superintendent with the person. Section 15 itself accordingly conferred no statutory authority to admit and treat informal patients. As Mr Chapman put it, such authority was rather derived from private law arrangements that were made.

[41] The argument in relation to the third period is rather different. It turns on s 14 of the 1969 Act which, Ms Cooper and Mr Chapman argued, disapplied the provisions in Part 2 concerning informal patients of those psychiatric hospitals which, during the third period, were operated by hospital boards. The argument of Mr Chapman and Ms Cooper here was that, if s 124 applied in respect of informal patients under the 1969 Act,[44] then it ceased to apply in respect of those hospitals which were transferred on 1 April 1972. These included Porirua Hospital in which the appellants were all patients. The essential argument was that from that date the 1969 Act was no longer a reference point for s 124. The appellants had become subject to the general hospital admission and treatment procedures and no acts of staff could be classified as in pursuance or intended pursuance of the 1969 Act.

[42] The Solicitor-General's argument for the respondent was that the statutes conferred power to admit patients on an informal basis for care and treatment during each of the three periods and acts of staff to that end were covered by the procedural requirements for bringing proceedings. In relation to the first and second periods, the terms of the provisions concerned, already set out, were relied on. In relation to the third period, commencing on 1 April 1972, the Solicitor-General argued that admission and treatment of all informally admitted patients continued to be in pursuance of (or where applicable intended pursuance of) the 1969 Act under s 18A and/or s 7. The Crown's argument was not advanced before the Associate Judge, the respondent there conceding that s 124 did not apply after transfer of control. The concession was withdrawn at the subsequent hearing in the High Court before Simon France J, when this argument was first advanced.

---

[44] As we conclude is the case.

Protective provisions

[43] The question before the Court is whether the alleged actions and omissions of doctors and other staff in relation to informal patients, which gave rise to intended civil or criminal proceedings, were done "in pursuance or intended pursuance of any of the provisions of" the mental health legislation in force at the relevant time. Section 6 of the 1935 amendment to the 1911 Act, and s 124 of the 1969 Act, both assume that doctors and staff members will be engaged to carry out the functions and exercise the powers provided for in the legislation. The principle underlying these provisions is long established:[45]

> … if the proper officers carrying out the provisions of the … Act … have acted in good faith and with reasonable care, even though they have made a mistake, even though the Act of Parliament gave them no jurisdiction in the particular case, and therefore there was what was called the ground of want of jurisdiction, nevertheless they are to be protected.

[44] In its context, the meaning of "pursuance" in each section is clear. It is "under the authority of". It is not necessary that the action was obligatory. "Intended pursuance" means in the belief that a provision which confers authority applied. Accordingly, when doctors or staff members were on duty and exercising functions of treatment and control of patients in the hospital under the authority of or in the belief they are acting under that authority, their actions were the subject of protection under whichever of ss 6 and 124 of the respective Act was in force at the time. The protection extended even where more force was used than reasonably necessary, provided that the officer concerned was purporting to undertake an authorised act in good faith and with due care. Protection does not extend if the circumstances fall outside of what is categorised as such an act.[46]

The 1961 Act: Crown authority to treat informal patients

[45] Section 3(1) of the 1961 amending Act stated that it was lawful for the superintendent, on a request by any person of stipulated age who was able to

---

45 *Shackleton v Swift* [1913] 2 KB 304 at p 314 (CA) per Vaughan Williams LJ.

46 *Pountney v Griffiths* at pp 335 – 336 (HL) per Lord Edmund Davies; and at p 319 per Lord Widgery CJ (CA).

understand the nature and effect of the request, "… [t]o admit that person to the institution for care and treatment as a voluntary inpatient". Section 3(3) added that a person admitted as a voluntary inpatient was "not liable to be detained in the institution". There was, however, an important qualification to that declaration. If the voluntary inpatient gave notice of intention to leave the institution, he or she could be detained for up to 24 hours. If the superintendent then decided to apply for a reception order the period of detention could be extended by four days and, once an application was made, further extended until the application was determined.[47] The reality of the admitted person's situation accordingly was that, although admission was voluntary in that the patient had to have the capacity to give and actually give consent, as Professor Fennell has put it, the patient once admitted "remained under doctors' orders"[48] being unable to leave without the agreement of the doctors.

[46] The 1961 amendment also introduced provisions for informal admission by superintendents of mentally infirm and subnormal patients who did not have capacity to consent. An application on a prescribed form was required, which in the case of a mentally subnormal person, had to be made by an adult who had responsibility for care of the patient. In all cases a medical practitioner's recommendation was also required. The superintendent then had discretionary power to admit the person to the institution for care and treatment.

[47] Prior to the 1961 amendment the 1911 Act had been more explicit concerning the status of the inpatient in stipulating that it was lawful for the superintendent to admit *and detain* any person as a voluntary boarder.[49] Mr Chapman invited us to read each of the 1961 provisions as doing no more than removing the obstacle in previous legislation to admission of any person to an institution other than by the formal committal process. That would leave the way clear for the argument that the power to admit or treat informal patients was derived from common law or perhaps, as he put it, a private law agreement rather than the legislation. There are, however, difficulties of principle in departing from a statutory

---

47 Section 3(3)(b) and (c).
48 Fennell, p 330.
49 Section 39(1) of the 1911 Act (repealed by s 16(5)(a) of the 1961 amendment).

scheme and relying on the common law or other source of authority for treatment of psychiatric patients, especially on a continuing as opposed to an emergency basis.[50] The resulting absence of prescribed procedures would be likely at times to be detrimental to the rights of patients. We also see no basis for circumvention of the clear statutory language. We are satisfied that both the 1961 Act's provisions, and those of the 1911 Act, went further than removing a prohibition and explicitly gave authorisation for the admission, care and treatment of informal patients, as well as for caring for and treating them while they were lawfully admitted. The superintendent could undertake such care and treatment without going through the committal process unless the patient gave notice of an intention to leave.

[48] Implicitly the statutory authorisation for the admission of persons for care and treatment extended to the exercise of control over such persons during the period in which they lawfully remained patients in the institution.

[49] It must follow that the statutory authorisation under s 3 of the 1961 Act of the actions of hospital staff in the course of care and treatment of patients and associated control is covered by the phrase "in pursuance or intended pursuance of" the relevant statute. Provided that requirements of good faith and reasonable care were met, such actions taken during the first period will enjoy the protection of s 6 of the 1935 amendment. We accept the submission on behalf of the respondent that the legislation also contemplated formulation of policies and procedures for such treatment, care and control and they would be covered by the phrase.

Leave requirements

[50] Under s 6 of the 1935 amendment, it is a condition of liability in any proceeding that the defendant has acted in bad faith or without reasonable care. As well, such proceedings may only be brought with leave of the High Court, which is not to be given unless the judge is satisfied there is substantial ground for that contention. In *Angland v Payne*[51] Smith J held that in order to be so "satisfied" it

---

50 See Dawson, "Necessitous Detention and the Informal Patient" (1999) 115 LQR 40, p 44 and "The Law of Emergency Psychiatric Detention" [1999] NZ Law Review 275, p 294.

51 [1944] NZLR 610 (CA).

was necessary that a judge, after weighing opposing contentions, reach a clear conclusion that a substantial ground existed. This required that there be a solid argument, being one with reasonable prospects of success.[52] The onus was placed on the applicant. Prior to 1935 the law had not included a leave requirement. It had allowed a defendant to apply for a proceeding to be stayed if there were no reasonable ground for alleging want of good faith or reasonable care.

[51] The purpose of the closely similar protective provision in United Kingdom legislation was said to be:[53]

> Patients under the Mental Health Act may generally be inherently likely to harass those concerned with them by groundless charges and litigation, and may therefore have to suffer modification of the general right of free access to the courts. But they are, on the other hand, a class of citizen which experience has shown to be peculiarly vulnerable. I therefore presume to suggest that the operation of section 141 should be kept under close scrutiny by Parliament and the Department of Health and Social Security.

[52] The appellants have invited us to read down the scope of the protective provisions or the provisions authorising care, treatment and control in the legislation following the 1961 amendment. They refer to the guarantee in the New Zealand Bill of Rights Act 1990 of right of access to the courts under s 27(3), the duty of the courts to prefer rights consistent interpretations of statutes,[54] and the common law presumption of interpretation that recourse to the courts for determination of rights is not to be excluded except by clear words.[55] However, in *Seal v Chief Constable of South Wales Police*,[56] Lord Bingham, on behalf of a majority of the House of Lords, held that the protection of those responsible for the care of mental patients from being harassed by litigation was a legitimate objective in limitation of rights of access to the court.[57] He also said that the limitation involved in the English protective provisions did not impair the very essence of the right because the threshold for obtaining leave had been set at a "very unexacting level".[58] An applicant with an arguable case would always obtain leave.

---

52 At p 626.
53 *Pountney v Griffiths* [1976] AC 314 at p 329 (HL) per Lord Simon.
54 Under s 6 of the New Zealand Bill of Rights Act 1990.
55 See *Pyx Granite Co Ltd v Ministry of Housing and Local Government* [1960] AC 260 at p 286 (HL) per Viscount Simonds.
56 [2007] 1 WLR 1910 at p 1917 (HL).
57 Under art 6(1) of the European Convention on Human Rights.
58 At p 1917.

[53] Under the New Zealand provision there was a further requirement that the application for leave had to be brought within six months of the act complained of unless it gave rise to continuing injury or damage. Historically there were many statutes containing provisions protecting certain persons, usually public authorities, against certain kinds of legal proceedings by prescribing a briefer period of limitation than that generally available.[59] The objective of such provisions as s 6 in this respect was to ensure that the defendant had prompt notice of the intention to seek leave to bring such proceedings. These provisions belong to another era but their meaning is clear beyond argument.

The 1969 Act

(a) Crown authority to treat informal patients

[54] The position was no different during the second period which ran for two years after the 1969 Act came into effect on 1 April 1970. The 1969 Act, in its definition of "informal patients" in s 2, and in providing for their admission in s 15, did not continue with the distinctions in the categories of informal patients that had been provided for in the 1961 legislation. There were also no longer requirements for applications to be made in specified form by the person concerned, a responsible carer, or another person. Section 15(1) authorised admission for treatment "pursuant to any arrangements made with" the superintendent of persons who might benefit from care and treatment. The section explicitly conferred a discretion on the superintendent. Hospital authorities were also permitted to allow persons to remain after they had ceased to be liable to be detained. The authority to admit and treat patients was given by the statute as it had been under the 1961 legislation. The reference to "arrangements" in the section does not alter the statutory character of that authority.[60]

---

59 See the discussion in G P Barton, "Limitation Periods for the Protection of Public Authorities" (1960 – 1962) 3 VUWLR 133.

60 Under s 17 the position in relation to authority was the same in respect of those informal patients who at the time of commencement of the 1969 Act were inmates having been admitted under specified provisions of earlier legislation.

[55] Section 124 was the provision giving protection to those who acted under the 1969 Act and was not materially different to s 6 of the 1935 amendment to the 1911 Act. That provision applied during the second period to protect the doctors and staff who acted under the 1969 Act with good faith and reasonable care.

(b) Authority of hospital boards to treat informal patients

[56] The next question is whether that remained the position after the control of most psychiatric hospitals was transferred from central government to the separate administrative structure for the control of general hospitals under the Hospitals Act 1957.

[57] The 1969 Act provided for the first time that psychiatric hospitals could be carried on by hospital boards in accordance with the 1957 Act.[61] This was in addition to the Crown's continuing power to do so through the Mental Health Division of the Department of Health. The Minister was empowered, with a board's consent, to transfer to it control of a psychiatric hospital.[62] The board concerned was then required to carry on the hospital, effectively as a going concern.[63] Hospitals under the 1957 Act could concurrently be psychiatric hospitals under the 1969 Act.

[58] The purpose of integration of the work of psychiatric hospitals, with those of general hospitals, was specifically referred to in the Act.[64] That policy was also emphasised in the speech of the Minister of Health on the introduction of the Bill:[65]

> Provision is also made for the gradual integration of psychiatric hospitals with public hospitals during the transitional period until psychiatric hospitals pass to hospital board control. Informal patients in psychiatric hospitals will be on the same footing as patients in public hospitals as far as administration of their estates is concerned. These are only some of the improvements that have been made to the 1967 Bill. This Bill is a comprehensive consolidation and revision of the Mental Health Act 1911 and its amendments. It brings up to date, in line with modern thinking, our mental health legislation and endeavours where practicable to remove any unfavourable distinction between psychiatric patients and general hospital patients.

---

61 In s 7(1).
62 Section 7(2).
63 Section 7(3).
64 In s 7(8).
65 Hon D N McKay (16 August 1968) 356 NZPD at p 1417.

[59] We have already referred to procedures for admission and treatment in psychiatric hospitals of those who were informal patients under Part 2 of the 1969 Act. As well, s 16 empowered the superintendent of a psychiatric hospital to apply for a reception order in respect of admitted informal patients which gave authority to detain pending determination of the application.

[60] The 1969 Act also made different provision for informal patients, once its provisions empowering the government to transfer control of psychiatric hospitals to hospital boards had been exercised. Section 14 provided that, other than as provided in s 18A, nothing in Part 2 of the 1969 Act dealing with "Informal Patients" applied to hospitals controlled by hospital boards. Section 18A gave s 16 continuing effect in relation to informal patients in institutions under hospital board control so that the hospital authorities could detain them pending determination of an application for a reception order.[66] Section 18A(3) also declared that nothing in ss 14, 15 or 18 of the 1969 Act limited or affected the discretion of a hospital board to admit persons to hospitals it carried on.

[61] We start with the ordinary meaning of the statutory provisions concerned. On that meaning s 14, as amended, disapplied the provisions of Part 2 of the 1969 Act in respect of "Informal Patients" when control of a psychiatric hospital was transferred to a hospital board. Section 14 also disapplied s 15, which previously had provided statutory authority to superintendents to admit informal patients for care and treatment with associated powers to detain if a reception order was sought. Accordingly, on the ordinary meaning of s 14, there was no longer any operating provision conferring authority to care for or control informal patients in the care of hospital boards in the 1969 Act. At this point, s 124 had no provision to attach to in the 1969 Act in respect of the treatment of informally admitted patients in the care of hospital board hospitals unless they tried to leave without the agreement of the hospital authorities. Part 2 (and s 124) continued to apply to informal patients in the minority of psychiatric hospitals, control of which was retained by the Crown. Those provisions also continued to apply to committed patients and special patients who were not affected by s 14.

---

66 Section 18A(1). Section 18A came into effect on 1 April 1972.

[62] The next question is whether this ordinary meaning of s 14 was qualified by s 18A. Section 18A(1) says that s 16 continues to apply in respect of informally admitted patients in a psychiatric hospital. That is not concerned with the status of patients who are admitted and remain patients without seeking to depart the hospital. Section 18A(3) says that nothing in ss 14, 15 and 18 is to limit the discretion of a hospital board to admit persons. This language does not confer any power to admit or treat in respect of informally admitted patients. It prevents the provisions of the sections concerned having a contextual effect of limiting a discretion of a hospital board to admit a person. That is all it does.

[63] Turning to the context of these provisions, we have already cited from the Minister's introductory speech to the House when the Mental Health Bill was introduced.[67] The Minister emphasised that part of the purpose was to remove unfavourable distinction between psychiatric patients and general hospital patients. Earlier he also said that changes had been made:[68]

> … to encourage the use of informal procedures in the admission and treatment of patients; in fact, wherever possible the whole underlying philosophy of the Bill is to avoid all unnecessary differences between the management of psychiatric patients and other medical patients.

[64] Contextual clarification of the meaning and effect of s 14 is also provided by the explanatory note to the amended version of the 1969 Bill. It said of the provision which became s 14:[69]

> *Clause 14* is new, and provides that this Part is not to apply to hospitals conducted by Hospital Boards or patients admitted to such hospitals. The reason is that Boards have sufficient authority under the Hospitals Act 1957 to admit patients to their institutions without formality.

[65] These aspects of the legislative history provide contextual support for the meaning of s 14 and s 18A that we consider are their ordinary meaning.

---

67 At para [58] above.
68 At pp 1416 – 1417.
69 Mental Health Bill, Explanatory Note (1968) at p vii.

[66] The purpose of s 14 was to bring those patients whose admission for treatment as inpatients was not under the formal procedure for committed patients within the regime that applied to general hospital services as far as possible. Counsel did not point to any provision in the Hospitals Act directly authorising admission and treatment generally and the appeal does not require us to identify whether the source of that power was, implicitly, the 1957 statute, the common law, or some other basis. What is significant is that the purpose as well as the context confirms the ordinary meaning of the language of s 14, which was to take the legal basis for admission and treatment of informal patients coming under the care of hospital boards out of the 1969 Act. The effect of that meaning is that s 124 has no reference provision in the 1969 Act to cover acts in respect of such patients.

[67] It was suggested to us by the Solicitor-General that this approach to interpreting the 1969 Act would have the unsatisfactory consequence of increased exposure of staff to legal action. We are not persuaded of that. The scope of s 124 should not be exaggerated. It did not provide an immunity from suit. It made it a condition of liability that the defendant had acted in bad faith or without reasonable care. It also gave protection against initiation of any proceedings without first obtaining leave and it imposed a time limit for applying. The legislative intention was not to bar any proceeding having merit and brought promptly. Secondly, it is said there are anomalies in that s 124 will apply to give protection to staff actions in relation to some patients, but not others, in the same institution. We agree that the fact that psychiatric hospitals and psychiatric wards of general hospitals contemporaneously maintain and care for committed patients, alongside those whose presence is informal, certainly means that patients had to meet different procedural requirements if they wished to bring proceedings. But that is not a factor which tells strongly on the question of the meaning of the statutory language. Thirdly it is said, correctly, that staff managing informal patients will have different degrees of protection according to whether they work in psychiatric hospitals, control of which was transferred, or others which remained under Crown control. This is simply the consequence of the decision to give the Minister a discretion as to which psychiatric hospitals should continue to be under the Crown's management. It does not have any bearing on the scope of protection given.

[68] Finally it was submitted that the effect of this meaning, if so understood at the relevant time, might have incentivised hospital staff to seek committal of patients who might otherwise have been informally admitted if trouble was feared. The policy of increasing the extent of informal admission no doubt brought many pressures on staff but we see no reason to conclude that such "incentives" were ever likely to present a real problem.

[69] The statutory scheme for the admission and treatment of mentally unwell persons in New Zealand was deregulated in the 1969 Act. The change in legislative policy seemingly reflected concern over harmful social effects of overuse of the certification process, including associated social stigma, and greater awareness that mental illness is usually susceptible to treatment which should be encouraged. Some steps were taken during the first transitional stage of reforms under the 1969 Act which abolished previous categorisation of informal patients for whom different bases for admission were prescribed. The second stage commenced when the majority of psychiatric hospitals was transferred to hospital board control. The 1969 Act provided that its provisions concerning informal admission and treatment of informal patients would then no longer apply. The main exception, stipulated in s 18A, was where the superintendent decided to apply for a reception order in respect of a person who had been admitted under the informal procedure.

[70] Prior to the transfer of control to hospital boards under the 1969 Act, the restrictions on bringing proceedings clearly applied and were effective. As they were a limitation on the right of access to the courts, the question of statutory interpretation in relation to the regime following transfer of control is not whether the limitation was clearly removed, as the Court of Appeal posed it.[70] The true question is whether the limitation on the right of access was clearly maintained as part of the new regime. We are not persuaded that it was.

[71] The provision in s 18A precluding ss 14 and 15 in particular from having the effect of limiting the discretion of boards to admit any person to their hospitals under

---

[70] At para [143] cited above at para [17].

their general powers was obviously added in 1972 out of caution. This was the original purpose of s 14, as the explanatory note to the amended Bill states. Section 18A(3) simply confirmed it. The policy underlying s 124 was based historically on a perception that psychiatric hospital patients would be inherently likely to bring groundless litigation. That policy has, however, over the years become the subject of academic criticism. For example Brenda Hoggett, in her text on mental health law, has said:[71]

> But only a minority of patients, even of those compulsorily detained, are suffering from disorders which make it at all likely that they will harass other people with groundless accusations. Rather more of them are suffering from disorders which make it likely that they will not complain at all, even if they have every reason to do so. There is no evidence that the floodgates would open if section 139 were entirely repealed. There is very much more evidence, from a series of reports and investigations, that mental patients are in a peculiarly powerless position which merits, if anything, extra safeguards rather than the removal of those available to everyone else.

[72] It is entirely consistent with the purpose of deregulation, itself based in part on changing social attitudes to persons needing treatment for mental conditions, that the special protection given to doctors and hospital staff members against vexatious proceedings should no longer apply following transfer of control of institutions to the general hospital system. In this way the overall deregulatory purpose tells against the Solicitor-General's argument that s 18A should be read as authorising admission and treatment of these patients. It favours the argument of the appellants and the amicus. Deregulation reflected a legislative policy that was concerned to ensure all patients other than those who had to be committed should be treated in the same manner as general patients. That also is consistent with the ordinary meaning of s 14 which took all admission and treatment of the group outside of the 1969 Act.

[73] We are satisfied that the policy of protecting staff against harassment from vexatious legal proceedings, which over the years was criticised by academic writers, did not survive deregulation insofar as it applied to informally admitted patients unless and until steps were required to have them formally detained.

---

[71] Brenda M Hoggett, *Mental Health Law* (2nd ed, 1984), p 345.

[74] Section 124 accordingly ceased to apply to informal patients after 1 April 1972, unless application was made for them to be detained under s 16. The Crown's original concession in the High Court, since withdrawn, was rightly made.

Conclusion

[75] For these reasons we allow the appeal against the Court of Appeal's finding that s 124 of the 1969 Act applies to proceedings arising from acts taken in the course of treatment and care of informal patients of hospital board psychiatric hospitals after 31 March 1972. Otherwise the appeal is dismissed.

[76] We refer the proceedings that were before the Court of Appeal back to the High Court for resolution in accordance with the decision of this Court.

Solicitors:
S M Cooper, Wellington for Appellants
Crown Law Office, Wellington for Respondent
Johnston Lawrence, Wellington for Amicus