INTERIM ORDER UNTIL FURTHER ORDER OF THIS COURT PROHIBITING PUBLICATION OF NAME, ADDRESS, OCCUPATION OR IDENTIFYING PARTICULARS OF DEFENDANT PURSUANT TO S 200 OF THE CRIMINAL PROCEDURE ACT 2011. SEE PARAGRAPH [65]. SEE http://www.legislation.govt.nz/act/public/2011/0081/latest/DLM3360346.html

IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

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

CRI-2024-091-002373
[2025] NZHC 3503

THE KING

v

W

Hearing:	13 November 2025
Appearances:	G J Burston and B Wilkins for the Crown G M Fairbrother for Defendant
Judgment:	13 November 2025

JUDGMENT OF GRICE J
(Insanity and disposition hearing)
(Anonymous version)

Introduction

[1] Mr W[1] has been charged with attempted murder.[2] He has entered a plea of not guilty by virtue of insanity.

[2] This Judge-alone hearing is being held under the Criminal Procedure (Mentally Impaired Persons) Act 2003 (the CP(MIP) Act). Counsel have agreed on this process. Section 20 of the CP(MIP) Act sets out a process for a judge to make a finding of act proven, but not criminally responsible on account of insanity. If Mr W was insane within the meaning of s 23 of the Crimes Act 1961 at the time of the commission of the attempted murder, then I must find him not guilty on account of insanity.

[3] The purpose of this hearing is for me to decide whether that is my finding. If it is, then I must consider the question of appropriate disposition, given the current state of Mr W's mental health.

Factual background

[4] The summary of facts which follows is largely based on the police summary of facts.

[5] The victim was a cyclist hit by Mr W in his car. The victim and the defendant were not known to each other.

[6] Mr W travelled from his home address to the area of the collision some distance away, sometime between Friday 27 December 2024 and Saturday 28 December 2024. At about 1.40 am on 28 December 2024, Mr W was sitting in his stationary car on Marine Parade in Paraparaumu. The victim and a friend rode past him on bicycles. Mr W started his car, did a U-turn and accelerated on the wrong side of the road to deliberately ram the victim with the bumper of his car. The

---

1 An interim non-publication order of the defendant's name and identifying particulars is in place pending the hearing of an application for a permanent suppression order and further order of this Court. The defendant's name is anonymised in the published version of this judgment. Other identifying particulars have also been redacted using square brackets.

2 Crimes Act 1961, s 173 — maximum penalty 14 years' imprisonment. Charges of failing to stop or ascertain injury were withdrawn before the hearing.

victim hit the windscreen of Mr W's car. Mr W made no attempt to stop and assist the victim. Instead, he stopped about 500 metres away and called 111 to inform police that he had hit a cyclist. When the police arrived, they found Mr W's car unattended, but located him a short time later.

[7] The victim sustained multiple injuries, including a compound fracture to his leg and a head injury. His bicycle was also significantly damaged.

[8] In explanation, the Mr W stated that he intended to kill the person on the bike, because he "wanted to sleep" and believed the cyclist was acting intimidatingly towards him. In a statement to police immediately after the incident, Mr W admitted the actions that led to the charge. He was candid about wanting to kill the cyclist and using his car to do so. He aimed his car at the cyclist and drove at him with the intention to kill — indeed he thought he had killed the victim and expressed considerable surprise in the interview that he had not.

[9] The witnesses to the incident and the victim confirmed in their statements that the incident had played out as described by Mr W.

Acts proven

[10] Before I go on to consider the question of insanity, I must be satisfied on the balance of probabilities that the evidence against Mr W is sufficient to establish that he in fact caused the acts that form the basis of the offence with which he is charged.[3]

[11] The Crown and the defence agree that there is a proper basis on which the Court can make a finding of acts proven based on the agreed summary of facts that I have just read.

[12] Having regard to the agreed summary of facts and to the Crown's acknowledgement, as well as the contents of Mr W's statement to the police and the confirmation by his counsel that no issue is taken with the facts as outlined, I find that,

---

3 Criminal Procedure (Mentally Impaired Persons) Act 2003 [CP(MIP) Act], s 10(2).

on the balance of probabilities, Mr W attempted to kill the victim in the circumstances that form the basis of the charge of attempted murder.

Procedural background

[13] A formal finding under s 8A(2)(b) of the CP(MIP) Act was made that Mr W was fit to stand trial.[4] The Judge noted that the Court had received reports from two health assessors under s 38 of the CP(MIP) Act.[5] The reports prepared by those assessors, consultant psychologist Kerry Reader and psychiatrist Dr James Cooney, addressed Mr W's fitness to stand trial and whether he had the defence of insanity available to him. Ms Reader and Dr Cooney each prepared two reports. Both initially considered Mr W was unfit to stand trial. However, in updated reports, they both expressed the view that he was fit to stand trial.

[14] Based on medical reports, the prosecution and defence have jointly requested this Judge-alone insanity hearing. As a result, this hearing was allocated to determine the question of insanity and, if Mr W is acquitted on the ground of insanity, the question of appropriate disposition.

Law relating to insanity

[15] I turn now to the first stage of the hearing, which is to determine the question of whether Mr W is or is not criminally responsible in terms of s 20 of the CP(MIP) Act, on account of insanity.

[16] Insanity is described in s 23 of the Crimes Act as follows:

> (1) Every one shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved.
>
> (2) No person shall be convicted of an offence by reason of an act done or omitted by him or her when labouring under natural imbecility or disease of the mind to such an extent as to render him or her incapable—
>
> (a) of understanding the nature and quality of the act or omission; or
>
> (b) of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

---

4 *R v W* [2025] NZHC 2161.
5 At [4].

[17] Under s 23, it is a defence to a charge if it is proven that the person was insane at the time of the offending. In this way, the law recognises that a person's thinking may, because of mental illness, be so disordered that he or she lacks the mental capacity to be held criminally responsible.

[18] Section 20(2) of the CP(MIP) Act provides that a Judge may make an insanity finding without the need for a jury trial, if three requirements are satisfied. Those requirements are:

> (a) the defendant indicates an intention to raise the defence of insanity; and
>
> (b) the prosecution agrees that the only reasonable verdict is a finding of act proven but not criminally responsible on account of insanity; and
>
> (c) the Judge is satisfied, on the basis of expert evidence, that the defendant was insane within the meaning of s 23 of the Crimes Act 1961 at the time of the act or omission that forms the basis of the offence with which the defendant is charged.

Application to the facts

[19] The first two requirements in s 20 have been satisfied here. The defendant indicated some time ago an intention to raise the defence of insanity, and the prosecution has agreed that the only reasonable verdict is a finding of acts proven but not criminally responsible on account of insanity. Both counsel have confirmed that this remains their position.

[20] As I have said, the third requirement is that the judge is satisfied, on the basis of expert evidence, that the defendant was insane within the meaning of s 23 of the Crimes Act at the time of the acts that form the basis of the offences with which the defendant is charged. The reason for this is put as follows:[6]

> [19] This is an important matter because it requires the Court, independently of the attitudes taken by the Crown and the accused, to reach its own conclusion as to whether or not an accused person was insane within the meaning of s 23 of the Crimes Act 1961 at the time of the commission of the offence. It is important that the Court not be seen to be a mere "rubber stamp" for the views expressed by professionals, or, indeed, by the Crown and the defence. That is an important safeguard because our criminal justice system generally requires crimes such as this to be determined by a jury and

---

6 *R v Brown-Howarth* HC Whangarei CRI-2006-088-2445, 10 December 2007.

> not by a Judge sitting alone. It is equally important, however, that in appropriate cases persons who intend to raise a defence of insanity be permitted to have that issue determined in an expedited form before a Judge rather than going through the ordeal of a trial by jury.

[21] Three mental health expert report writers have concluded that Mr W has a relevant mental disorder.

[22] I am satisfied based on the diagnostic conclusions of each report writer that Mr W was labouring under a disease of the mind at the time of the offending. The Crown and the defence independently reached that view following consideration of the reports and have highlighted, in particular, Dr Cooney's view, which is also reflective of the views of the other psychiatrist, Dr Jennifer Falce, as well as Ms Reader, a psychologist. What he said, with which I agree, demonstrates that the conclusion is inevitable.

[23] Dr Cooney summarises his diagnosis in his most recent report of 16 October 2025 as follows:

> In my opinion, [Mr W] has a mental disorder within the meaning of the Mental Health (Compulsory Assessment and Treatment) Act 1992. My impression is that he has a chronic psychotic process, likely schizoaffective disorder, as his early illness had an affective component consistent with mania. His presentation around the time of the offending represents an acute exacerbation of a chronic condition in the context of significant social stressors and substance use.
>
> He presents with an abnormal state of mind characterized by delusional beliefs, disorders of mood, and disturbances of volition that pose a serious danger to the health and safety of himself and others. While his symptoms have responded to antipsychotic medication (risperidone), he continues to require treatment and monitoring due to ongoing risk concerns and the need for stabilization.

[24] Dr Falce, having described the symptoms which she had observed, noted in her report of 25 August 2025:

> <u>Mental disorder as defined by the Mental Health Act</u>
>
> 48. In my opinion, [Mr W] has a severe and enduring mental illness, which is likely to be schizophreniform in nature. The presence of affective components indicate it may be unified appropriately as schizoaffective disorder. This is supported by its chronic nature, likely having been present to some extent since 2012, but intensified significantly over the last few years in the context of mounting life stressors and interpersonal

difficulties. Though much of his religious belief system is socially accepted, when he became unwell, this escalated to the extent that he was experiencing referential delusions that benign events were indicative of a higher conspiracy specifically directed toward him, with the express intent of causing him harm. This involved much more bizarre and less conventional bodies such as the Freemasons and included authoritarian agencies such as the Police and the Courts. The prompt and objective response to antipsychotics, reducing the irritability of his affect and the intensity of his persecutory beliefs, tends to support the diagnosis of a primary psychotic disorder.

49. This fits the definition of a "mental disorder" as defined by the Act; specifically, he experiences delusions of grandiose and persecutory natures, disorder of cognition in the form of tangentiality and flight of ideas, disorder of mood in the form of manic elevation, and disorder of volition from his chaotic and defensive behaviour. His illness results directly in a risk to others, as evidenced by his threatening [a family member] followed by the index offending …

Insanity within the meaning of Section 23 of the Crimes Act 1961

50. Contemporaneous clinical records to the index offending note an escalation in contacts across multiple services with increasing bizarreness. This includes involvement with the Emergency Department, CRS, police, and altercations with those close to him. Frequent themes are of being poisoned and persecuted. Unfortunately, in the local region, no contacts were made; notes allude to him being seen by the Crisis Assessment and Treatment Team (CATT) in Palmerston North, but I have not seen these files, and they appear not to be available in the electronic health record. I am unclear if they are handwritten somewhere. Regardless, there is a distinct pattern of contacts which retrospectively provide strong evidence of a deteriorating mental state and the emergence of persecutory delusional themes.

51. Of the alleged offending, [Mr W] has given a consistent account of the victim being in some way associated with the Devil and therefore the purported conspiracy against him. He endorsed either auditory hallucinations of the victim's thoughts or thought insertion phenomena (a type of thought interference) which confirmed the victim's intentions to kill him; he has also remarked that he saw the victim reach into his bag, which he interpreted to be evidence he was withdrawing a firearm. The evidence available suggests that [Mr W] then acted in what he believed to be self-defence. My assessment is that due to his disease of the mind, that being a psychotic disorder, he was incapable of knowing the moral wrongfulness of his actions. I therefore agree with Drs Cooney and Reader that [Mr W] has an insanity defence available to him.

[25] I am satisfied on the balance of probabilities[7] that Mr W's schizoaffective disorders, as described by the expert reports, constitute a disease of the mind in terms

7 *Cameron v R* [2021] NZCA 80, [2021] 3 NZLR 152 at [69].

of the Crimes Act definition of insanity. I am also satisfied that Mr W was so overwhelmed at the time with the abnormal delusions that he was incapable of knowing that his acts were morally wrong, having regard to the commonly accepted standards of right and wrong.

[26] The attack was preceded by several days of increasingly bizarre behaviour by Mr W, driven by his belief of persecution. Suffering from an acute mental illness, he attacked the victim by driving at him. This was following Mr W experiencing sudden and distinct auditory hallucinations of the victim's voice in his mind, which he interpreted as being able to hear the cyclist's thoughts, saying "I'm gonna kill you, cunt". The law recognises that Mr W cannot be held criminally responsible for his actions while he was insane in that way.

Finding of insanity

[27] I make a formal finding that Mr W was insane, within the meaning of s 23 of the Crimes Act, at the time he committed the offences.

[28] I therefore make a finding under s 20(1) of the CP(MIP) Act that:

(a) the acts are proven, namely that Mr W attempted to kill the victim on 28 December 2024; but

(b) Mr W is not criminally responsible for those acts on account of insanity.

[29] As a result, Mr W I find you not guilty on the charge of attempted murder on account of your insanity.[8] You are acquitted on that charge.

Victim impact statement

[30] Because of my finding that Mr W was insane at the time of the offending, he is not convicted and will not be sentenced for what he has done. Instead, the Court must make an order under the CP(MIP) Act.

---

8 CP(MIP) Act, s 20(1)(c).

[31] I will in a moment outline what the options for disposition are, but before I do that and importantly, before the Court is a victim impact statement prepared by the victim, which was read out by Detective Black. The victim suffered extensive injuries and the effects on him of being hit by Mr W's car will be for life.

[32] The victim's life has been changed. He received substantial injuries from the impact of the defendant's vehicle and being thrown from his bicycle. He had to undergo a full shoulder replacement, and is in constant pain from that. He also suffered a compound fracture to his leg. This also causes constant pain and will never return to normal. These injuries have curtailed his previously active lifestyle.

[33] The incident has also affected the victim mentally — his loss of independence and the pain have been hard to cope with. He also feels isolated from his friends, with whom he shared his active lifestyle. Sleeping is hard, as the pain wakes him. His ability to do certain jobs has also been limited, and the loss of his bicycle, mobile phone, and other personal items have put pressure on him financially.

Options for disposition

[34] Returning now to the options available in relation to disposition, ss 24 and 25 of the CP(MIP) Act outline the process for disposition of a proceeding where a defendant has been found insane. The relevant provisions of s 24 read:

> **24 Detention of defendant found unfit to stand trial or insane as special patient or special care recipient**
>
> (1) When the court has sufficient information on the condition of a defendant found unfit to stand trial or acquitted on account of his or her insanity, the court must—
>
> (a) consider all the circumstances of the case; and
>
> (b) consider the evidence of 1 or more health assessors as to whether the detention of the defendant in accordance with one of the orders specified in subsection (2) is necessary; and
>
> (c) make one of the orders referred to in paragraph (b) if it is satisfied that the making of the order is necessary in the interests of the public or any person or class of person who may be affected by the court's decision.

(2) The orders referred to in subsection (1) are that the defendant be detained—

(a) in a hospital as a special patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992; or

…

(3) Before the court makes an order specified in subsection (2)(a), the court must have received evidence, under subsection (1)(b), about the defendant from at least 1 health assessor who is a psychiatrist.

[35] Therefore, the Court must make an order under s 24(2) if it is satisfied that making the order is necessary in the interests of the public or any person or class of person who may be affected by the decision.

[36] Where the Court does not make an order under s 24(2), an order is instead required to be made under s 25, as follows:

25 Alternative decisions in respect of defendant unfit to stand trial or insane

(1) If, after considering the matters specified in section 24(1)(a) and (b) concerning a defendant found unfit to stand trial or acquitted on account of his or her insanity, the court is not satisfied that an order under section 24(2) is necessary, the court must deal with the defendant—

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

…

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

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

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

…

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

[37] The effect of the alternative orders under s 25 is outlined in s 26 of the CP(MIP) Act:

> **26 Effect of alternative orders**
>
> (1) An order made under section 25(1)(a) is to be regarded as a compulsory treatment order for the purposes of the Mental Health (Compulsory Assessment and Treatment) Act 1992, and, in making the order, the court must specify whether, for the purposes of that Act, the order takes effect as a community treatment order or as an inpatient order.
>
> …

[38] Relevantly, inpatient orders are outlined at s 30 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MH(CAT) Act):

> **30 Inpatient orders**
>
> (1) Every inpatient order shall require the continued detention of the patient in the hospital specified in the order, or (where the patient is being detained at some other hospital) the admission of the patient and his or her detention in the hospital so specified, for the purposes of treatment, and shall require the patient to accept that treatment.
>
> (2) If, at any time during the currency of the inpatient order, the responsible clinician considers that the patient can continue to be treated adequately as an outpatient, that clinician shall, by notice in writing,—
>
> (a) direct that the patient be discharged from the hospital; and
>
> (b) direct the patient to attend at the patient's place of residence, or at some other place nominated in the notice, for the purposes of treatment;—
>
> and, in such a case, the inpatient order shall thereafter be deemed to be and to have effect as a community treatment order as if the terms of the notice were the terms of the order.

[39] In summary, the Court must:

(a) Consider the evidence of one or more health assessors, at least one of whom is a psychiatrist, as to whether the detention of the defendant is necessary in the interests of the public or any person who may be affected by the decision.

(b) If satisfied that detention is necessary, then the Court is required to make an order that the defendant be detained, either as a special patient

under the MH(CAT) Act or as a special care recipient under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the IDCCR Act).[9]

(c) If the Court is not satisfied, then the Court must deal with the defendant under the disposition options outlined in s 25 of the CP(MIP) Act, which are:

(i) Ordering that the defendant be treated as a patient under the MH(CAT) Act or as a care recipient under the IDCCR Act.

(ii) Declining to make an order if the person is liable to a sentence of imprisonment otherwise imposed.

(iii) Ordering the immediate release of the defendant.

Evidence of the health assessors

[40] Dr Cooney and Dr Falce, psychiatrists, have both provided reports addressing disposition under ss 24 and 25. Ms Reader has also provided an updating report which notes that disposition is outside the scope of practice for a psychologist, and therefore defers to the opinions of Dr Cooney and Dr Falce.

[41] Both Dr Cooney and Dr Falce assess that Mr W's risk of further violence is directly connected to his state of psychosis. Dr Cooney says:

> [Mr W's] serious history of violence is directly connected to episodes of acute psychosis. His index offense occurred during a period of severe mental health deterioration when he experienced intense persecutory delusions and believed people were conspiring against him. He misinterpreted an innocent gesture from a cyclist as evidence of a weapon and felt compelled to act in what he perceived as self-defense.

[42] Similarly, Dr Falce's report states:

---

[9] The IDCCR Act is not relevant to the present case, therefore the applicable provisions have been excluded from the sections set out above.

> It seems deducible that, unless [Mr W] is seriously unwell, he does not pose a significant risk to himself or others. If he were to become unwell again, this risk would substantially increase.

[43] As the Crown notes, the likelihood of further violence is dependent on Mr W's mental state and, in the case of a relapse, there is a potential for further violence of high severity, including fatal violence.[10]

[44] The previous reports before the Court documented Mr W's improvement in mental state since he started being treated with Risperidone. As a result of that treatment his mental state returned to a point where the Court found him fit to stand trial. In his most recent report, Dr Cooney records:

> [Mr W's] current clinical presentation shows improvement following treatment. After initial resistance during his admission to [redacted], he engaged meaningfully with treatment and responded well to risperidone. His mental state examination now reveals no evidence of active psychotic symptoms. His speech is logical and goal-directed, without the thought disorder previously observed. The persecutory and religious delusions that drove his offense have resolved, and he denies any hallucinations or abnormal perceptual experiences.

[45] Both Dr Falce and Dr Cooney determined that ongoing mental health treatment of some form was required to reduce the risk of further offending. Dr Cooney's report concludes:

> It is my opinion that it is necessary in the interests of the public and himself that [Mr W] receive ongoing mental health treatment to reduce the chance of future offending. There is a clear nexus between [Mr W's] mental state and his risk of violence.

[46] Dr Falce expresses her views as:

> My recommendation is that the most effective way of preventing further offending is to ensure that [Mr W's] mental state is monitored and managed by a mental health team in a long-term, structured way. There is no doubt in my mind that compulsion under the Mental Health Act will be required as a minimum. Somewhat by coincidence this would mean that [Mr W's] driving licence could be removed, reducing the risk of similar offending.

[47] Dr Falce notes that "the natural course of his illness [is] difficult to predict. The evidence suggests that it is likely to be a relapsing and remitting psychotic illness."

---

[10] Ms Fairbrother, for the defendant, noted that [Mr W] had no history of violent offending, in a submission made after the disposition.

Dr Falce also considers that Mr W "was probably psychotic for at least two years prior to the alleged offending without ever coming to the attention of services due to violence or criminal behaviour".

[48] In assessing whether treatment should take the form of a special patient order under s 24 or treatment as a patient under s 25, both Dr Cooney and Dr Falce assessed the risks which would or could lead to a relapse of Mr W's psychotic symptoms. Each express concern about discontinuance of medication or disengagement with mental health services; each note Mr W's previous, consistently expressed, fear of needles, and that a return to cannabis use could exacerbate his symptoms.

[49] Dr Cooney notes that an important factor that he gave consideration to in assessing appropriate disposition was that Mr W now "demonstrates improved insight into his mental health condition" and:

> …recognizes the connection between his untreated psychosis and his offense, expressing genuine remorse for his actions and their impact on the victim. He understands the critical importance of medication, stating that the benefits "100% outweigh the negatives" despite side effects including dry mouth and headaches. This level of insight represents a significant protective factor, as it suggests he is more likely to recognize warning signs and seek help proactively.

[50] Dr Cooney considers that with appropriate treatment and support, the risk of Mr W's reoffending can be effectively managed in a community setting. As the Crown points out, Dr Cooney states that "[g]iven the critical importance of medication adherence to [Mr W's] stability, consideration should be given to long-acting injectable antipsychotic medication". In a similar vein, Dr Falce expresses the view that treatment of Mr W by depot injection is "vital", stating:

> By giving medications as an injection, compliance can be assured, and a consistent dose can be given. The treating team would be aware of exactly how much medication he was getting and could monitor his mental state with specific reference to his medication dosing. I do not feel that his needle phobia is a contraindication to this, as there are multiple options for management, including Cognitive Behavioural Therapy, Exposure Therapy, and use of anxiolytic pharmacological options. Giving a depot, even when the patient is declining it, is an option afforded by a Mental Health Act order.

[51] Dr Cooney's report as to disposition following a recent meeting with Mr W records Mr W's view on treatment by injection, expressed during that meeting as follows:

> He identifies medication adherence and support from clinicians and family as the main factors in his recovery. While expressing fear of injections, he indicates willingness to accept long-acting injectable antipsychotics if recommended by his treatment team, demonstrating commitment to treatment despite his anxiety about this intervention.

[52] Dr Cooney and Dr Falce both determine, "on balance", that a special patient order is not required, however that decision is not clear, and Dr Falce notes that "[Mr W's] case is not straightforward". She says there are "very good arguments both for and against a Special Patient order". Dr Cooney concludes that a community treatment order could allow for safe management of Mr W's risks "if sufficient safeguards are put in place".

[53] Dr Falce assessed whether a compulsory treatment order (as opposed to an order that Mr W be treated as a special patient) was sufficient to mitigate the risks in these terms, finding that:

> On balance, the risks [Mr W] poses *should* be able to be sufficiently managed by a Compulsory Treatment Order pursuant to the Mental Health Act, so long as all of the … conditions are possible and ensured. Conversely, given the severity of the offending, and the uncertainties around the risk of relapse, it may be that this is not sufficient assurance to the Court, and in that case, that a Special Patient order is preferable.

[54] The ultimate conclusion of Dr Cooney is:

> Given these considerations, and acknowledging the Court's ultimate discretion in this matter, my recommendation from a clinical perspective would be for disposition under section 25(1)(a) with a focus on robust community management rather than detention as a special patient under section 24. I recommend this disposition be effected through an inpatient order under section 26 of the CPMIP Act. This would allow for an injectable form of antipsychotic to be commenced, establishing connections with his community team, and a period of planning to support his community reintegration.

[55] Dr Falce's conclusion as to disposition was:

> …that a Mental Health Act order is required as a minimum, and that the Community Mental Health Teams should – in theory – be able to provide the recommendations above, including a depot, regular mental state review, and

> prompt recall to hospital in the case of non-compliance. Establishing [Mr W] on a depot regime of his medication, and connecting him with a team could theoretically be coordinated from [redacted], should he be returned there after these matters are heard in Court.

[56] The Crown submits, on the basis of the evidence before the Court (in particular the report of Dr Falce and the disposition report of Dr Cooney), that on balance, an order under s 24(2) that Mr W be detained in a hospital as a special patient under the MH(CAT) Act is not necessary in the interests of the public or any person or class of person who may be affected by the court's decision. However, the Crown notes that the report writers appear not to have reached this decision lightly, and in the case of Dr Falce, are explicit that there are factors that weigh both for and against detention as a special patient.

[57] The proceedings against Mr W, in the Crown's submission, therefore, fall to be determined under the disposition options contained in s 25(1) of the CP(MIP) Act. The report writers are clear that treatment of some form is required to reduce the risk of further violence. Accordingly, the Crown submits that there is no basis for the Court to determine that disposition by ordering the immediate release of Mr W under s 25(1)(d) is available or appropriate. Mr W is not intellectually disabled, nor otherwise liable to a sentence of imprisonment for life.

[58] An order under s 25(1)(a), that Mr W be treated as a patient under the MH(CAT) Act is submitted to be the only available, and most appropriate outcome.

[59] Where the Court makes an order that a defendant be treated as a patient under the MH(CAT) Act, it is required to specify whether that order is to be a community treatment order or an inpatient order.

[60] The Crown submits that the order imposed by the Court in relation to Mr W ought to be an inpatient order. Ms Fairbrother, having read the reports and discussed matters with Mr W and his family, also agrees.

[61] The seriousness of Mr W's offending and the close connection between the offending and the symptoms of his recurrent psychotic illness, is such that careful steps must be taken to ensure that he is subject to a robust treatment plan. Both health

assessors note that it is preferable that Mr W's medication be delivered by long-term intramuscular injections.

[62] In the Crown's submission, Mr W should be treated as an inpatient, establishing a robust treatment plan to support him fully upon becoming treated in the community. Mr W's treating clinician will be best placed to assess how and when Mr W should become subject to a community treatment order — a power which is afforded to the treating clinician of a defendant who receives an inpatient order.

[63] As noted, Ms Fairbrother for the defendant concurs with the views of the Crown. She notes that Mr W's mother has been keenly aware of the need for her son to continue treatment and she supports him in those endeavours. Mr W acknowledges the need for treatment and assistance. He wants to stay well.

Disposition order

[64] In those circumstances, I make a disposition order as follows: that the defendant be treated as a patient under s 25(1)(a) of the CP(MIP) Act and s 30 of the MH(CAT) Act and be detained as an inpatient at [redacted] under the Forensic Service of Te Whata Ora for the purposes of treatment, and require that the defendant accepts that treatment.

Suppression

[65] The interim order of non-publication of the defendant's name will continue until the determination of the application for a final suppression order.[11]

Grice J

Solicitors:
Luke Cunningham & Clere, Wellington for Crown

[11] At his first High Court appearance, the Judge made an interim order for suppression of the defendant's name: *R v [W]* HC Wellington CRI-2024-091-2373, 5 February 2025 (Minute of LaHood J). This was continued in subsequent minutes including on 22 August 2025, which was the last minute referring to suppression before this insanity and disposition hearing.