IN THE SUPREME COURT OF NEW ZEALAND SC 72/2008

BETWEEN **JLRB AND OTHERS**

Appellant

AND **CROWN HEALTH FINANCING AGENCY**

Respondent

Hearing:	2 April 2009
Court:	Elias CJ Blanchard J Tipping J McGrath J Wilson J
Appearances:	S M Cooper with K Ross for the Appellant Solicitor-General with U Jagose and L Hansen for the Respondent R Chapman as Amicus Curiae

CIVIL APPEAL

MS COOPER:

May it please Your Honour, my name is Ms Cooper and I appear with my learned friend Ms Ross.

ELIAS CJ:

Thank you Ms Cooper, Ms Ross.

SOLICITOR-GENERAL:

Ms Jagose and Ms Hansen appear with me for the respondent Your Honours.

ELIAS CJ:

Thank you Mr Collins.

MR CHAPMAN:

May it please Your Honours I appear as amicus.

ELIAS CJ:

Thank you. Sorry my computer is playing up. Yes, Ms Cooper.

MS COOPER:

I just wanted to commence with some opening remarks. As Your Honours are aware, this matter has wound its way from the High Court Associate Judge level in 2005 through the various stages of appeal and now this Court and the final issue that we are addressing you on today is the issue of whether informal patients are caught by the leave and immunity provisions of the 1969 and its predecessor the 1911 Act.

The issue of whether the leave and immunity requirements contained in those two Acts applies to involuntary and informal patients is an important question of law. The issue affects a large number of plaintiffs whose cases are already before the High Court and also those whose cases are yet to be filed. As has been noted in the submissions, the appellant's claims in this particular appeal are representative of some 280 plaintiffs who have already commenced proceedings in the High Court at Wellington and as I've just noted there are still others to be filed.

Considering the position of the now six appellants directly affected by the decision to be made by this Court, it is important to illustrate that each of the plaintiffs at various points had periods when they were informal patients under the 1969 Act both before and after the hospitals were transferred to the hospital boards and that's illustrated in appendix 1 to my submissions. I don't know if you want to have a look at that but that illustrates it to say that all of those six appellants had periods when they were informal patients. I think it's important to observe that for many of the plaintiffs whose claims have been

filed, they certainly had periods or spent their entire period in hospital as informal patients so this decision will affect all of those plaintiffs potentially and it will also affect whether aspects of or indeed perhaps for some patients whether their claims are able to proceed.

I thought it might be useful to start giving some examples as to how the Court's decision will actually affect particular allegations that are raised in the pleadings that are before the High Court already. I start first that in relation to the six appellants, that all of them were adolescents at the time of their admission to Porirua Hospital and indeed for pretty much each of these plaintiffs they remained adolescents throughout the period of their care. Four of those six appellants, and that's Mr L, Mc, R and Ms W were administered ECT is one of the allegations in the pleadings. In relation to Mr Mc and Ms W, it specifically pleaded that they were administered ECT as punishment for misbehaving and there is an argument depending on the interpretation of the immunity leave provisions that that could be covered. This is particularly so if the Crown succeeds in its argument that any lawful conduct was an act in pursuance or intended pursuance of the Act.

In relation to each of the appellants who was administered ECT, the allegation is that their diagnosis did not support such treatment and that's referred to in the amended statements of claim. There is also a related argument of consent. Again, if the Crown's argument today succeeds, then allegations of this nature will be subject to the leave and immunity provisions and will be struck out as not having been brought – as having been brought out of time. If the appellant's argument succeeds on the other hand they won't be struck out. Having said that, the Crown isn't left without a defence. It's clear then that the Crown would be able to rely on the common law defences that are available to it such as consent or necessity and of course there are a raft of other common law defences that are potentially open to the Crown.

The next –

ELIAS CJ:

Well I haven't looked, sorry, at the statement of claim but the causes of action –

MS COOPER:

Are tort causes of action so they're essentially negligence, directly vicarious liability negligence, non-delegable duty of care, assault and battery.

ELIAS CJ:

Yes.

MS COOPER:

I think in respect of some there will be a false imprisonment cause of action and that will relate particularly to seclusion and of course that's going to be a cause of action that is particularly of pertinence to informal patients. If the leave and immunity provisions apply to informal patients then a false imprisonment cause of action is going to be virtually impossible to argue. On the other hand, of course, if informal patients are not subject to the leave and immunity provisions that cause of action remains and, as I've said, there are still the defences available to the Crown under the common law position of false imprisonment, causes of action whether it's detention and whether it's authorised, whether it's necessity et cetera.

McGRATH J:

Ms Cooper, can I just ask for clarification of how these proceedings started? You, or it may have been Mr Chapman's client filed a statement of claim –

MS COOPER:

Yes.

McGRATH J:

– and then, with an application. Was that an application for leave under the Act or was it related to something else?

MS COOPER:

The application for leave Sir was in relation to the Limitation Act.

McGRATH J:

I see.

MS COOPER:

The way in which we have commenced the proceedings is on the basis that the allegations that we have complained about are not subject to the leave and immunity provisions of the Mental Health Act and therefore weren't obliged to apply for leave under that Act. Essentially that's the issue that's wound its way through to the Court of Appeal.

McGRATH J:

That's clarified that for me. I wasn't sure what those applications were for –

MS COOPER:

Yes, the Limitation Act Sir.

McGRATH J:

And it was at that stage the Crown came in with its strike out application?

MS COOPER:

Yes, that's right. They applied to strike out the proceedings on the basis of the Mental Health Act provision and also on the basis of the Limitation Act as well.

McGRATH J:

Thank you.

MS COOPER:

I just also wanted to –

ELIAS CJ:

Sorry, do we actually have the statement of claim? We've got the applications to strike out but do we have the statement?

MS COOPER:

Yes, you certainly do Your Honour. It's in the case on appeal, volume 1, tab 4.

ELIAS CJ:

Yes, thank you very much.

MS COOPER:

If you want me to refer you to the particular paragraphs that I've just been referring –

ELIAS CJ:

No, that's fine, thank you.

MS COOPER:

I also thought it would be useful to illustrate how this Court's decision will impact on the plaintiffs in respect of allegations of physical assaults. Now, each of the plaintiffs has alleged physical assaults by staff members and by other patients. I think it's fair to say that as a consequence of the decisions that we've had, culminating in the Court of Appeal decision, while most of the allegations regarding staff assaults will not be within the immunity provision because they have been held by the Court of Appeal, if anything amounts to an offence, it's outside of the immunity provision and striking was such an offence. Assaults on adolescents by other patients have been held to be acts in pursuance of the Act, that's in the context of it arising in terms of the management of the hospital.

ELIAS CJ:

That seems a very odd – I hadn't picked that up from the Court of Appeal judgment.

MS COOPER:

That's not an issue that actually arises from the Court of Appeal judgment, it actually comes from the lower judgments of the High Court. There it was held that, there was a distinction made between assaults perpetrated by staff and those that were perpetrated by patients for example. The clear distinction was made that assaults perpetrated by patients, other patients, effectively came under the running of the hospital or the management of the hospital and therefore were caught by the immunity and leave provisions.

ELIAS CJ:

Will you at some stage just give me the reference to where I find that in the judgment of the High Court?

MS COOPER:

Yes, yes, I'll help you with that. I'll get my learned junior to find that and I'll come back to that.

ELIAS CJ:

Thank you.

MS COOPER:

Just in terms of the assault allegations, I have simply noted that in terms of the pleadings, they are of a serious nature. For example, Mr B has alleged beatings and fights with mainly adult patients in his claim. Mr L has alleged being punched and pushed against the wall by a patient. Mr Mc has alleged multiple beatings by mainly adult psychiatric patients and he has a specific allegation of being kicked in the head by an adult patient.

TIPPING J:

Does the seriousness of the alleged assaults trench in any way on the issues that we have to resolve?

MS COOPER:

No. I'm highlighting them Sir to say that, in terms of the appellants, it is an important issue –

TIPPING J:

Yes, look I don't need any persuasion of that. I just wanted to understand why you were mentioning it, in case I was missing something.

MS COOPER:

No, I'm simply saying that there are serious allegations of assault –

TIPPING J:

Yes, of course –

MS COOPER:

– and I suppose the context of raising that Sir, is to say that in terms of the seriousness, often the seriousness of the assaults perpetrated by other patients was just as, and in some contexts actually more serious, than the assaults perpetrated by staff.

TIPPING J:

The degree of seriousness of these alleged actions is not relevant to either of the two questions that we have to asked as a matter of law?

MS COOPER:

No, no.

TIPPING J:

No. Thank you.

MS COOPER:

I think the reason I'm raising it Sir, is that part of the Crown's complaint is that the argument that we're running now would mean that different legal principles would apply to actions being taken in relation to different classes of patients

and that's in the Crown's submissions at paragraph 89. So, part of what I'm illustrating is that the effect of the decisions already made is that that is already the case. That there are already, if one could say it, anomalous decisions where some things will be categorised as being covered by the leave and immunity provisions and other acts that are of the same nature will not, depending who the perpetrator is or depending on the circumstances. So the mere fact that there are different legal principles that may apply, is not in and of itself an answer and it is certainly the contention of the appellants that different legal principles have always applied to informal patients.

TIPPING J:

Speaking for myself, this is complicated enough already. I would rather you concentrated on the points that are actually going to matter for the leave – on the two issues because frankly otherwise you just don't know where everything is fitting in.

MS COOPER:

I think Sir, the point that I'm making is that the fact that this is going to create in – this is going to result in different, I suppose legal principles is exactly the point I'm making, applying. If we succeed, that informal patients have different legal principles applying as opposed to committed patients, is not in of itself a strong argument, if that's the context of the legislation and that's supported by the case law.

TIPPING J:

I understand that point.

MS COOPER:

And that's really the short point Sir and to say that the effect really of the decisions is already that that happens.

TIPPING J:

Right.

MS COOPER:

The other point I just wanted to make is that throughout the course of the various hearings, we've argued on behalf of the appellants that the leave and immunity provisions don't apply to informal patients. It's not simply a technical argument and it's my submission that there is a body of case law which I've already referred to in written submissions, stating that the scope of immunity provisions must be strictly interpreted and particularly where the effect of such provisions is to deny citizens the right of access to the Courts. I do note that the Court of Appeal –

ELIAS CJ:

This is really properly – I'm just wondering whether it's right to characterise this as an immunity provision. If it doesn't protect against want of care, it's really the filter and in particular the time limit that is the problem, isn't it, for your clients?

MS COOPER:

Well, I think it's probably useful to start with the basis in which the starting premise of the Crown's argument is that we've actually had to argue through and the Crown's starting premise Your Honour was that, everything that was done by a staff member unless it was a serious sexual assault, was covered by the immunity provision in section 124 and its predecessor. So, every other sexual assault, every physical assault, every act of seclusion, every act, even if it was a punishment, that was covered by the immunity provision and that's the argument that we've had to track through up to the Court of Appeal and have that argument sorted out. So, it is – if the Crown's interpretation of the immunity provision had been accepted, it certainly would have been a very powerful immunity provision because it would have actually barred the plaintiffs from bringing claims in respect of anything other than serious sexual assaults. Everything else would have been deemed to have been an act in pursuance or intended pursuance of the Act, you then would have had to have shown –

ELIAS CJ:

With the consequence that they would have to have leave to bring the action.

MS COOPER:

Yes.

ELIAS CJ:

I'm really querying your emphasis on the case law which says that immunity provisions are to be strictly construed when this, it seems to me, is more properly characterised as a filter mechanism. It does have of course the consequence that the time limit is extremely tight and that's the real nub, it seems to me, of the problem that you have.

MS COOPER:

Well, with the six month time limit in fact all of these claims would be out of time –

ELIAS CJ:

Yes.

MS COOPER:

– because the acts that are complained about really date between the 1960s and the 1980s.

ELIAS CJ:

Yes.

MS COOPER:

I think, with respect Your Honour, though, I still think that, as I say, if the Crown's argument had been accepted this would have been a very powerful immunity provision as well. It certainly knocked – I accept that the leave provision causes one aspect of the problem but the immunity aspect of the provision also creates issues as well and as I say, one example of that is whether assaults by other patients can be brought and of course the decisions

of the lower Courts has been that that is actually part of the management or running of the hospital and therefore subject to the immunity provision and that would be something for which a plaintiff would have to apply for leave before they could bring that action, whereas acts that are outside of the scope of the immunity are not acts for which the plaintiffs actually have to apply for leave in advance, they can simply bring their claim.

BLANCHARD J:

But you would still have to establish lack of reasonable care, wouldn't you?

MS COOPER:

Not if it is outside of the scope of the immunity but certainly if it was covered by the scope of the immunity, then you'd have to –

BLANCHARD J:

But if you are suing in negligence, you are going to have to establish a lack of reasonable care.

MS COOPER:

Yes.

BLANCHARD J:

That's why the Chief Justice is putting it to you that this is not really an immunity provision. It's a control provision rather than an immunity provision. It creates a screen that you've got to get through.

TIPPING J:

The control is that you must have a substantial ground for the allegation. You can make the claim provided you persuade a Judge that you've got a substantial ground for the contention as the section puts it.

MS COOPER:

Well yes but the first question, and that's the question that we've actually been debating through the lower courts is whether – first of all, the first question is

whether it's an act in pursuance or intended pursuance of the Act and that's the first question. You don't actually start to consider whether there's an allegation of bad faith or –

BLANCHARD J:

Yes but that doesn't give the Crown an immunity in itself.

MS COOPER:

If it's an act in pursuance or intended pursuance of the Act, then the Crown has an immunity and the onus then falls –

BLANCHARD J:

Unless the person has acted in bad faith or without reasonable care.

MS COOPER:

Well no, if the person has acted in bad faith or without reasonable care. So yes, sorry Sir, you're correct, unless –

BLANCHARD J:

I'm just reading from the statute.

MS COOPER:

Yes.

BLANCHARD J:

Anyway I'm not sure that there's much point in debating this further.

TIPPING J:

The real question is, what is meant, the first crucial question is, what is the scope of the words "in pursuance of"? The hidden section talks about acting under authority.

MS COOPER:

Yes.

TIPPING J:

So I suppose your argument is that "pursuance of" means as authorised by the Act?

MS COOPER:

Absolutely.

TIPPING J:

It's as simple as that.

MS COOPER:

It is. It's as simple as that and that's an issue obviously in terms of what's authorised by the Act is the critical issue and the fundamental issue insofar as the argument relates to informal patients, what is –

TIPPING J:

So the question is, on your argument, whether people who are there voluntarily and received treatment on that basis, whether that treatment is either expressly or implicitly authorised by the Act?

MS COOPER:

That's correct Sir and that's the point I –

TIPPING J:

Is the issue anymore complicated conceptually than that?

MS COOPER:

No and in fact that was the point I was just going to say is that the basic premise for the appellants is that the mental health legislation was not of itself the source of the authority for treatment of informal patients unlike the position of committed patients where the Act clearly was the source of authority for treatment and care of committed patients.

ELIAS CJ:

Well I wonder really about that because the Act, on my reading of it, seems to be simply about, with a few tack-on provisions, seems to be about reception and –

MS COOPER:

And detention.

ELIAS CJ:

And detention.

MS COOPER:

Yes and care and treatment. If you look at section 25 of the 1969 Act, that refers to care and treatment –

ELIAS CJ:

Well I am starting at the 1911 Act because that's where it first came in but the other gets superimposed over it –

MS COOPER:

Yes.

ELIAS CJ:

But even then the care and treatment referred to is about record keeping, isn't it, or something of that sort?

MS COOPER:

If you look at, I think in terms of the lower Act, the 1911 Act, section 3 is probably the starting point there and it's clear there that they're talking about receiving and detaining them as a mentally defective person.

TIPPING J:

But doesn't, I know you've been taken back quite rightly to the earlier Act –

MS COOPER:

Yes.

TIPPING J:

But looking at section 25 of the 1969 Act, that section is express authority for the giving of care and treatment?

MS COOPER:

It is, yes. That's exactly what I was saying. That's express authority and that's why I'm distinguishing the position –

TIPPING J:

But only in respect of those to whom the section applies.

MS COOPER:

Absolutely and that's committed patients.

TIPPING J:

Yes.

MS COOPER:

Yes, and that's exactly my point. That one – the language of the 1969 Act at least is quite clear in terms of the authority to treat and provide care for and in fact training and guidance I think was the rest of the language of section 25, is quite clear in section 25 that the Act is the source of the authority for treatment of committed patients.

TIPPING J:

And your point, as I understand it, is the simple one, that nowhere in the Act is there the same express authority to provide care and treatment for these involuntary people?

MS COOPER:

Absolutely and that's the simple point Sir.

McGRATH J:

Is it relevant that section 25 of the 1969 Act appears much wider than its predecessor in the 1911 Act which was section 6?

MS COOPER:

I think essentially in terms of the way in which the Courts have interpreted the two Acts, they've interpreted them in a manner that is consistent and I think that would partly explain the Court's I suppose defining the Act as covering acts that were incidental to the right to detain and – because clearly in terms of the role of a mental hospital it's always been to provide treatment and – so the case law in that would include the cases that I've referred to including the cases that are relevant around here but also would include *Pountney v Griffiths* and *Seal* for example. I think the Courts have always been clear that anything that's incidental to treatment of a committed patient including control will be covered by the terms of the Act.

McGRATH J:

Yes I'm just really looking at the heading of the two provisions. One appears to be a provision for getting authority to take and detain –

MS COOPER:

Yes.

McGRATH J:

Which I understand from your submissions was the focus of the 1911 Act –

MS COOPER:

It was.

McGRATH J:

– as against the previous position.

MS COOPER:

Yes, that's right.

McGRATH J:

But by 1925 they're talking about sufficient authority for detention and treatment.

MS COOPER:

And treatment, exactly.

McGRATH J:

Yes.

MS COOPER:

So I think it's certainly reflecting the change in political and I suppose medical views of care and treatment of psychiatric patients and each legislation has – I suppose the 1992 Act is the most modern version of that, that certainly the historic legislation, the 1911 and before that the Lunatic Act et cetera, they had focused very much on control and custody –

McGRATH J:

Yes.

MS COOPER:

And then, yes, as the more medical, I suppose, model became reinforced, the issues of care and treatment were introduced into the legislation.

TIPPING J:

Ms Cooper, I think the point, looking at it, as I see it, the point you've got to meet is simply this, that why is the authority to receive voluntary patients, because the legal bar was removed –

MS COOPER:

Yes.

TIPPING J:

– and that seems to me to amount to authority to receive them, why is that not necessarily also authority to care and treat them, that being the very purpose of them being there?

MS COOPER:

Well Sir again I wouldn't accept that either of section 15 or its predecessor section 39 are necessarily authority in that sense to admit. I'd say they were descriptive of the position, in other words, it was simply saying that it's no longer unlawful and those words needed to be in the legislation because under the previous Acts –

TIPPING J:

Are you saying that removing the ban, or the power, is not implicitly authorising them?

MS COOPER:

It's recognising, as in the Hospitals Act for example, and suppose if I can compare that with the Hospitals Act, it's recognising in describing the status that those patients were able to be admitted for treatment into the hospitals but that doesn't then describe the source of the authority for that treatment which is a different issue. So it's – in terms of the mental health legislation it was necessary to say that it was permissible to accept voluntary patients into psychiatric hospitals because the previous position had been that it had been unlawful to do so, so it was necessary to describe that expressly in the legislation. But it's my submission Sir that that's – it's in the same manner as saying in the Hospitals Act, for example, and that's why I've cited the Hospitals Act, that they were permitted to admit and treat patients. At the end of the day that doesn't then go on to say that the source of the power for treatment is derived from the legislation because clearly for a general patient the source of the power to treat is derived from consent for common law.

TIPPING J:

So the removal of the legal bar on admission doesn't amount to authority to treat? That's the proposition as I understand it.

MS COOPER:

That – the proposition is, exactly. That in and of itself is not authority to treat. It's simply recognising the legal change and if one, as I say, if one compares it with the Hospitals Act –

ELIAS CJ:

Did the Hospitals Act apply at all times?

MS COOPER:

The Hospitals Act came into force in 1957 and there was a predecessor to that which I think my learned friend has addressed in his submissions, I'm not sure but certainly from 1957 onwards the Hospitals Act was in force and so that would certainly cover those patients who were effected by the 1961 amendment.

ELIAS CJ:

My question is, I have assumed that the Hospitals Act applied to these institutions as well?

MS COOPER:

No.

ELIAS CJ:

No, all right.

MS COOPER:

No, no, it didn't and that's part of the importance of the –

ELIAS CJ:

I see.

MS COOPER:

– issue in terms of section 14 and the effect of that.

ELIAS CJ:

Yes, yes.

MS COOPER:

It certainly applied to all hospitals run by hospital boards, and subsequently the area health boards, but in terms of hospitals run by the state and up until 1972 all psychiatric hospitals were run by the State, except for a small number of units that were attached to general hospitals and that's an issue that I will also cover as well because that may be an explanation to section 14.

ELIAS CJ:

Did mental, I don't know what they are called, what these institutions –

BLANCHARD J:

Psychiatric.

ELIAS CJ:

Psychiatric hospitals weren't subject to both the Mental Health Act and the Hospitals Act?

MS COOPER:

No, that's correct. Psychiatric hospitals were specifically –

ELIAS CJ:

Only subject to the Mental Health Act?

MS COOPER:

That's correct. They were specifically designed and created under the Mental Health Act and they were licensed under the Mental Health Act and

there were other institutions that could be licensed under the Mental Health Act.

It's probably worthwhile, with Your Honour's leave, at this point to actually turn to my written submissions and start addressing those points. I think we've already started on some of them. I'm not sure whether you want me to – Your Honour, I've just had my learned junior hand me up the references to Justice Simon France's judgment in which he addressed the issue of assaults by other patients. It's the case on appeal, volume 1, tab 6, page 193 and it's paragraph 108.

ELIAS CJ:
Thank you.

MS COOPER:
I'm not sure whether it is of assistance to start with the decisions of the lower Courts or whether you want really, if I just can start into the substance of the submissions?

ELIAS CJ:
Yes, develop your submissions I think.

MS COOPER:
I will start then at page 5 which looks at the interpretation of the legislation, starting first with the 1911 Act. As we've already discussed, that was the first Act which introduced the concept of voluntary boarder and, as we've discussed, prior to that time it was an offence to admit a patient to a lunatic asylum, as they then were, except by order of a magistrate. Now, I've noted just because it was an issue referred to by His Honour Justice Hammond in the Court of Appeal, that under this Act a voluntary boarder could not be a patient, under the 1911 Act. The Act was passed to consolidate and amend the law relating to the care and control of mentally defective persons.

Here, I just want to respond to the Crown's submissions at paragraph 3, where the submission is made that the scheme of the legislation was designed to regulate the conduct of staff in relation to patients. It's my submission that that's a flawed argument and in fact incorrect. The conduct of staff was regulated in separate documents, largely issued by the Department of Health and further, the professional staff would have also been subject to their codes of conduct as being members of professional bodies. Essentially the law was, as described, to actually direct and provide provision in relation to the care and control of mentally defective persons and that was the focus of the legislation. Under the 1911 Act, a mentally defective person was defined as one who, owing to his mental condition requires oversight, care or control for his own good or in the public interest and who, according to the nature of his mental defect and to the degree of oversight, care or control deemed to be necessary is included in one of the following classes and they are set out in the appendix. Clearly, as I say, the Acts have moved in terms of defining what is included as a mentally defective person.

I think one of the important issues that is to be emphasised, is that if someone was defined as a mentally defective person and was to become subject to the committal procedures of the Act, there were quite a large number of procedures designed to protect those patients. I've described the laborious committal procedure in order to be detained at the hospital. First of all, you couldn't be received or detained as a mentally defective person unless there was an authority of a reception order made by a magistrate. I think the importance of section 3 is – and it clearly defined that anyone who was in hospital subject to a reception order had to be a mentally defective person, whereas a voluntary boarder under section 39 didn't necessarily have to be and that is important in terms of some of the Crown's argument later on. A magistrate could only make the order for reception and attention of a committed patient upon an application being made in the prescribed form and that had to be accompanied by a medical certification also in prescribed form. A magistrate had power to call further medical practitioners and witnesses.

TIPPING J:

When the 11 Act introduced this concept of a voluntary boarder, did it deal with what could happen with, or what the regime was for voluntary boarders?

MS COOPER:

That's section 39 Sir which I come on to.

TIPPING J:

Right.

MS COOPER:

That's at paragraph 19, so I'll certainly come on to the regime of the voluntary boarders. Just describing though that in terms of committed patients, as I say, there was a laborious procedure for committing them and they had to be, as I say, the medical certificates were in a prescribed form and the point of making that is – sorry, Your Honour, did –

ELIAS CJ:

No, I'm sorry. Justice Tipping was just simply raising with me whether it is necessary for you to go through all your submissions because we have of course read it. It may be that you might make your points through taking us to the legislation, if you think it is particularly relevant.

MS COOPER:

Yes, right.

ELIAS CJ:

It's quite an elaborate system that was set in place in 1911 even for voluntary boarders, with time limits and the ability to move from one status to the other and restrictions on self-discharge and so on until people were assessed.

TIPPING J:

That would be of particular interest to me because it's the predecessor if you like of the present, or the relevant set up.

MS COOPER:

Yes. Well and even the modern set up –

TIPPING J:

The scheme for the compulsory people doesn't seem to me to be so important as the scheme for the voluntary people.

MS COOPER:

Yes. Well, I think the reason that I was highlighting the scheme for committed patients was to say that there were a large number of protective processes in place –

TIPPING J:

Yes, I understand that and it's there.

MS COOPER:

– before they could be contained, pursuant to the Act, and that's important because I think one of the emphases that the appellants need to make is that this group of people are always vulnerable. Whether or not they were subject to the legislation, they are a vulnerable group of people by very virtue, by the very nature of the reason they are in hospital and therefore one has to be looking to see what the intention was of the legislation in terms of whether – how far the Act was to apply and particularly and obviously in this case the scope of the immunity provisions or the leave and immunity provisions.

So looking at section 39, obviously the issue there was first that it was made lawful for a superintendent to admit and detain any person in that institution. So that was reversing the previous position of it having been unlawful and I just noted that that's permissive rather than mandatory but the admission of a boarder was contingent on that person signing a request in a prescribed form and that had to contain a statement that the person was aware that they were liable to be detained in the institution for seven days after any application in writing for them to be discharged had been received by the superintendent.

Then – so essentially that's all that section 39 said. So they had to be competent to sign a form, so there is a basis there of it being at least that under the 1911 Act, a basis of informed consent. And then section 40 is important because that's the provision it then provided for discharge of a voluntary boarder so that was either to be on the order of the Minister or superintendent of the institution or, as had been set out above, on the boarder's own application in writing. And as I've noted, it wasn't lawful to detain the boarder for longer than seven days after the day on which the application was received, unless of course the Act was invoked to commit them.

ELIAS CJ:

It seems to me, and it may not be helpful to press on like this and don't accept the invitation if it isn't, that under the 1911 – that the critical thing is the change between the 1911 Act to the 1969 Act in relation to treatment because it does seem to me that the 1911 Act really authorises, the Crown may say inferentially authorises treatment, but that it is principally concerned with reception and restraint and even the provisions relating to voluntary boarders have a whole regime in there for actually restraining people while their status is assessed.

MS COOPER:

And I think Ma'am that is an issue that is actually consistent throughout the legislation in fact, and even in the 1992 Act, and this is a point I want to actually emphasise, it's still actually in the 1992 Act so –

TIPPING J:

What is?

MS COOPER:

The power to restrain an informal patient to invoke the – to invoke the committal procedures.

TIPPING J:

Right.

MS COOPER:

It's just in each legislation, in fact the 1969 Act, part of the effect was actually to, in a sense, almost abolish that in a way and it actually got reintroduced in the 1992 Act in the sense that patients could be actually held for six hours. So the 1969 Act was actually kind of the most permissive version of that.

TIPPING J:

But you see, let's take 40B as an example. "It shall not be lawful to detain for longer than seven days."

MS COOPER:

Yes.

TIPPING J:

It clearly must be read as saying it is lawful to detain for up to seven days?

MS COOPER:

Yes, I accept that Sir, and to that extent I would accept that – I don't think I can argue that if that was the ground on which the Crown was raising a defence, in other words, that a voluntary boarder was detained during that seven day period for the purpose of assessment, I would have to accept that that was an act in pursuance of the Act. I couldn't argue that because that's specifically authorised by the Act and in terms – and other subsequent legislation to the effect that the Act was invoked to detain for the purposes that are specifically authorised by the Act. I can't argue that.

TIPPING J:

Well what is it in the next piece of legislation that makes the position better from your client's point of view?

MS COOPER:

Well in the 1969 Act –

ELIAS CJ:

It makes it worse –

MS COOPER:

– in fact there was no power –

ELIAS CJ:

Treatment.

MS COOPER:

Well one treatment but also in the 1969 Act there was actually no power to detain at all so the power to detain had gone. The 1961 amendment reduced it to 24 hours but the 1969 Act removed it completely except to the extent of section 16 that said that a person could be detained again for that purpose of invoking a reception order so –

ELIAS CJ:

So there was a power to –

MS COOPER:

Section 16, yes. But it didn't, like it – each Act in a sense became less restrictive so – and I suspect Your Honours that that actually reflected the doctor resource more than anything else. That there were so few doctors, for example, in the earlier days and the hospitals were huge, that it might realistically have taken seven days to actually have someone assessed and actually have the reception order process invoked. By the time the 1969 Act, the 1961 amendment came around, that had been reduced to 24 hours. The 1969 Act actually didn't set any time limit within which – in fact it actually there was no, there was nothing in the Act at all about detention except in that limited section 16 which was that you could detain a person for the purpose of applying for a reception order. And as I've said in the 1992 Act in fact in some

ways that was reintroduced the power to detain an informal patient for the purposes of invoking the Act.

ELIAS CJ:

But why is this actually relevant to the argument that we have to hear because you're accepting that insofar as restraint is clearly authorised in all this legislation –

MS COOPER:

Yes.

ELIAS CJ:

– it comes within the section 124 immunity or gateway.

MS COOPER:

Yes.

ELIAS CJ:

So isn't the critical thing that you have to convince us of, the fact that it is only in relation to restraint that that immunity/gateway attaches?

MS COOPER:

Yes.

ELIAS CJ:

And one of the big difficulties you have is that although the earlier legislation seems more promising, although there are questions of what's implied in it, what people can do while someone is retained, the critical thing is that in the subsequent legislation there's specific reference to treatment.

MS COOPER:

The issue though, with respect Your Honour, is the source of that power for treatment and in both the 1911 Act and the 1969 Act the source of that power for treatment was in the 1911 Act a request for treatment so the patient had to

provide a written request for treatment and more obviously in the 1969 Act it was pursuant to arrangements between the patient and the superintendent. So that was the source of the power for treatment.

ELIAS CJ:

But what was the source of the power for treatment in respect of committed patients?

MS COOPER:

Section 25. So that's –

ELIAS CJ:

Under the 1911 Act?

MS COOPER:

Oh, under the 1911 Act, section 6 and section 3.

ELIAS CJ:

Sorry, I just want to have a look at that.

McGRATH J:

It's only implicit under section 6?

MS COOPER:

Yes.

ELIAS CJ:

And 3.

MS COOPER:

And you, also, I think too, you also need to look at the definition of a mentally defective person.

ELIAS CJ:

You see I would have thought that there was a purpose of construction of the immunity provision in respect of the 1911 Act that it was only concerned with compulsory detention and that that actually applied both to voluntary and involuntary patients but you run into difficulties with the subsequent legislation in respect of both, well you have an argument that the source of the authority to treat remains in the –

MS COOPER:

Common law.

ELIAS CJ:

Yes, in the request.

MS COOPER:

Yes, yes, well it – in the 1969 Act it had to be pursuant to arrangements.

TIPPING J:

What section was that you mentioned in the 1969 Act that talked about arrangements?

MS COOPER:

Section 15.

TIPPING J:

Section 15?

MS COOPER:

Yes. If you look at paragraph 29 of my submissions that sets out section 15.

TIPPING J:

The section 15 gives the power to act on an arrangement?

MS COOPER:

That's right. But the issue there is –

TIPPING J:

It's getting rather fine, isn't it, to say that that is not an authorisation?

MS COOPER:

Well –

TIPPING J:

A power to act on an arrangement.

MS COOPER:

Again Sir I compare that with the position of a general hospital patient. The fact is that a general hospital patient, the arrangement to treat is subject to an arrangement as well so the argument that I'm running Sir is that the Act described the arrangement that needed to be entered into or the authority of which was the basis for treatment and for an informal patient the authority for their treatment was an arrangement and that put it within the common law context rather than under the auspices of the authority of the Act.

TIPPING J:

But what I'm putting to you is it's a very fine distinction.

MS COOPER:

It's an important one though.

TIPPING J:

Well it may be from your client's point of view very important but I'm just ruminating on the fact that the idea that the Act authorises the superintendent to act on or pursuant to any arrangements made with him. You are saying that the source of the authority is the arrangements not the section giving him the power to act on.

MS COOPER:

Yes.

BLANCHARD J:

The arrangements are not necessarily going to deal with treatment.

MS COOPER:

That was the point of the arrangements was to address the issue of treatment.

BLANCHARD J:

How did it do that, what would a typical arrangement say?

MS COOPER:

Often those arrangements dealt with, for example, whether the person would have ECT. So, I mean, there were specifically treatment issues that were agreed –

ELIAS CJ:

How were these arrangements done, undertaken? Were there formal documents?

MS COOPER:

Well, under the 1969 Act, in fact there was no need for formality, however one can see on some patients' files that there were sometimes documents signed specifically in relation to the ambit of treatment. One of the big issues of course was that if ECT was going to be given, electro convulsive therapy was going to be given, typically there was a consent form signed for that because of recognising the invasive nature of that therapy. In other contexts, one could see specific consent forms in relation, for example, to particular medication. I suspect again, if one compares that with the practice of hospital boards, that a lot of it would have been done orally and, you know well, we think this is good for you, are you okay with that, yes.

TIPPING J:

Just coming back to section 15.

MS COOPER:

Yes.

TIPPING J:

We must try and take this as a composite, in respect of any person who in his opinion would benefit from psychiatric care and treatment. So, the superintendent is of the opinion that the person would benefit, arrangements are made but surely it is left to the discretion of the superintendent as to what psychiatric care and treatment would be for the benefit of the person. The arrangements surely aren't intended to stipulate with precision how many doses of this or how many kinds of that or whatever?

MS COOPER:

I accept that and I think that would still be the position now Sir. I mean, most arrangements as to treatment now are not going to be very stipulative as to exact doses or how often you take things –

TIPPING J:

Yes but the connotation of this to my mind, that is subject to further argument, is that the arrangements spoken of are simply logistical. You know, will you take so-and-so for a couple of weeks or something like that and see what's going on, so in they go.

MS COOPER:

Yes.

TIPPING J:

The idea that the treatment that is then given, or the care that is then given is not pursuant to the Act, with great respect, seems to me to be a bit far fetched.

BLANCHARD J:

My brother's point is certainly strengthened if you look at the long title to the Act which specifically says it's an Act to make further provision for the care and treatment of mentally disordered persons.

MS COOPER:

Except that informal patients by definition Sir, were not necessarily mentally disordered and so by very –

TIPPING J:

You wouldn't have to be satisfied they were mentally disordered to take them and have a look at them.

MS COOPER:

No, not for voluntary patients, they did not have to be mentally disordered –

TIPPING J:

That's the whole point of the system isn't it, that you don't have that pre-condition?

MS COOPER:

Yes.

TIPPING J:

You can take them in and say well, actually there's nothing much wrong with you, out you go.

MS COOPER:

Yes.

TIPPING J:

Or and I don't want to sound facetious, or, oh dear, yes I think there is something we can do for you, we recommend you stay. Or if it's at a level, we will apply for a reception order.

MS COOPER:

That's right.

WILSON J:

On your argument, what is the purpose of section 15?

MS COOPER:

It's essentially repeating what the purpose was of the predecessor in section 39, that was again to declare that it wasn't unlawful to admit voluntary patients in for treatment in a psychiatric hospital. So that was one of the main purposes. Again, simply declaring that what was otherwise unlawful was a lawful act –

WILSON J:

Isn't the implication of section 15 that authority beyond the arrangements is required?

MS COOPER:

My submission Sir, is that the only authority which gave authority to treat was the arrangements that were entered into between the patient and the superintendent.

WILSON J:

Well, I ask again, if that's the case, why do you need section 15?

MS COOPER:

Section 15, well as I say because it was again just simply acknowledging that what would otherwise have been unlawful was lawful and in fact, I think Sir the point is that by the time the 1992 Act came, there was no equivalent. So, I acknowledge that issue Sir and that is probably reflective in the 1992 Act where it's gone completely. I think the other issue there is, the other reason why section 15 is there is partly in recognition of the fact that there was going to be the transfer of the hospitals that was already well in contemplation from

the Crown to the hospital boards. So, they needed to have a regime that dealt with informal patients as part of that transfer coming along. I think probably one of the valid questions is that if that construction – if those words pursuant to any arrangement didn't mean anything, then they didn't need to be there. They must have meant something. I mean, that section could have actually made sense without those words being there at all. It could have actually said that, I'll just find it again. It could have actually just said, the superintendent of a hospital may in his discretion treat a person without admitting him to hospital – may in his discretion, in respect of any person, you could actually just take those words out. So, the fact that those words are there, they have to be given some meaning.

ELIAS CJ:

Your submission is that if these powers can be said to be exercised in pursuance of the Act, the words "pursuant to any arrangements" are unnecessary?

MS COOPER:

They aren't necessary, no.

BLANCHARD J:

Could they have been there so that the arrangements would govern the situation if there were any arrangements?

MS COOPER:

Except that they're a precursor aren't they, they're a requirement. In fact, the superintendent wasn't able to admit, well had to admit pursuant to arrangements –

BLANCHARD J:

Well, well, I don't think that's right.

ELIAS CJ:

No.

BLANCHARD J:

It's pursuant to any arrangements. That presupposes that there may not be arrangements.

TIPPING J:

If there's no arrangement, there's no power.

MS COOPER:

Yes.

BLANCHARD J:

Otherwise it would have said pursuant to the arrangements.

MS COOPER:

I think that that's simply widening the scope as to what the ambit of any arrangements could cover Sir. I think that –

BLANCHARD J:

How does it do that? This is surely an authority to the superintendent to admit people on a voluntary basis to hospital for treatment.

MS COOPER:

Yes, except the issue Sir is that then where does one, where does the power to actually treat derive from and as I say, the critical argument being made on behalf of the appellants is that the power was actually derived from the common law, so it was derived from those arrangements –

BLANCHARD J:

The power could equally have come from this section, that that's its purpose.

MS COOPER:

Well, I think then Sir, one needs to compare that section with section 25 which was clearly – if one looks at section 25, it related to committed patients. The language of the Act is deliberately very different.

ELIAS CJ:

Would it also be the case that if what is being put to you was the meaning of section 15, it really would be subject to any arrangements made with him, whereas this doesn't envisage that the power to treat is pursuant to arrangements?

MS COOPER:

Yes, yes.

ELIAS CJ:

Sorry, section 25.

MS COOPER:

Yes, I was just comparing that with section 25, where it's clear, and that's in relation to committed patients, that that clearly states every reception order shall be a sufficient authority to the person named therein and appointed for that person to take the person so found to be mentally disordered and to deliver him forthwith to the superintendent and that superintendent may accordingly receive and detain him, or if he is already in the hospital, detain him in pursuance of the order and may give him –

ELIAS CJ:

That's quite a significant reference to, that if he's already in the hospital, he now is to be from henceforth detained pursuant to the order.

MS COOPER:

That's right.

ELIAS CJ:

Rather than, as you would say it, pursuant to the arrangement?

MS COOPER:

Exactly, and may give him care and treatment and where appropriate training and occupation in hospital so that's – I think one needs to compare the language of section 25, which is directive and clearly states an authority to do so, with the language of section 15 and there is a distinct difference in the power that's been given to the superintendent under section 25 on the one hand and section 15 on the other hand. I don't think, I mean there can't be any argument that the power to treat in care for a committed patient is derived, from section 25, is derived from the statute.

TIPPING J:

The power to admit for treatment in the voluntary sense derives surely from subsection (b) of subsection (1)? The arrangement collateral if you like to the power because the section reads, "The superintendent of the hospital may admit the person to the hospital for treatment without a reception order…" blah blah blah blah, "…if in his opinion and he can do so pursuant to arrangement."

MS COOPER:

Yes.

TIPPING J:

Now what's worrying me is the fineness of the distinction that you're seeking to draw. I take the point about the comparison with section 25 but that apparently goes straight back to section 6 whereas section 15 apparently goes back to certain sections of the 1961 Act so this is a sort of, bit of a patchwork quilt this legislation.

MS COOPER:

It is.

ELIAS CJ:

Isn't section 15 arguably both authority because otherwise the superintendent would be arguably exceeding his authority and also the source of the power over the patient. The source of the power over the patient is pursuant to any arrangement, the superintendent also has to be authorised in terms of what he can spend public money on to act pursuant to that arrangement.

MS COOPER:

It certainly permitted the superintendent, as section 39 did in the 1911 Act, it permitted the superintendent to admit voluntary patients.

ELIAS CJ:

Yes.

MS COOPER:

So in that sense it authorised the voluntary patients to be admitted into the hospital. As I say the issue then though is in terms of treatment and care, where did that authority derive from and it's the position for the appellant simply that that derived from under the, you know the 1911 Act, it essentially is saying that it basically was by way of request under the 1911 Act and under the 1969 Act it was pursuant to any arrangements and that was the source of the authority rather than the Act itself. When one looks at the Act in its entirety, there were very few provisions that actually related to informal patients as one would have expected and that –

ELIAS CJ:

But how does it really help you because then you just – then you have to go immediately to section 124 and you have to say that the acts done in relation to somebody who has entered into arrangements and been therefore properly admitted are not acts done in pursuance or intended pursuance of any of the provisions of the Act.

MS COOPER:

Yes.

ELIAS CJ:

Well how do you exclude the section 15 patient, even accepting what you say is right, that he's accepted pursuant to the arrangements entered into, why is that nevertheless outside section 124?

MS COOPER:

Because, Your Honour, that then puts it within the ambit of the common law. That puts it within the ambit of consent to treatment and therefore within the ambit of the common law which is outside of the control of the Act. It's then no longer an act in pursuance or intended pursuance of the Act and I'll come onto the case law but particularly the English case law would be supportive of that argument. That where the source of the authority for the treatment is not in itself derived from the Act, and that's where the importance I think of comparing section 25 and section 15 is – if the source of the authority is actually the arrangement, we then get into the ambit of the common law –

ELIAS CJ:

But it's picked up by section 15. The mechanism for utilising section 15 procedure may depend on arrangements but the superintendent is nevertheless surely acting in pursuance or intended pursuance of section 15?

MS COOPER:

As I say Ma'am, the issue is though, is the source of that power actually derived from the Act itself or is it actually – if the source of the power is actually the arrangements, as in the Hospitals Act, because if one looks at the Hospitals Act there are similar provisions there to admit, accept and admit people for treatment, but one wouldn't say that the power then to admit and treat is derived from the Hospitals Act. It's actually derived from the arrangements between the patient and the hospital in which case –

WILSON J:

It could be both though, couldn't it? It's not necessarily exclusively one or the other surely?

MS COOPER:

I think then though Your Honour, you need to look then to see what the Act actually authorises and in that context I accept that there were some things that, with respect, informal patients that would be an act in pursuance of the Act. So for example under the 1911 Act if they were detained for that seven day period under the 1911 Act or the 24 hour period under the 1961 amendment, I would accept that that would be an act in pursuance of the Act. But those are not the acts of course that are complained about in the pleadings. The acts that are complained about in the pleadings are treatment acts and –

TIPPING J:

Just pause.

MS COOPER:

Yes.

TIPPING J:

Surely if we're going to make these distinctions between arrangements and Act, the superintendent and his delegates are acting under the authority, if you like, of both the arrangements and the Act because both are necessary. There have to be arrangements – I'm completely lost Ms Cooper. What I think I was saying –

MS COOPER:

You were saying about the authority of the Act.

TIPPING J:

In reality it's pursuant to both because you need both. The superintendent needs both the arrangements, on that view of it, and the Act to back him up. Without one or the other, arguably he wouldn't be acting lawfully.

MS COOPER:

Well again sir I think if one compares that with the position of a patient under the Hospitals Act, a general patient, that wouldn't necessarily be the case. As I say the Hospitals Act too gave specific power to admit people for treatment and gave power to create bylaws for detention, even detention et cetera, but at the end of the day that Act wouldn't have defined, while it gave that power or recognised that, it was descriptive, it didn't actually – that wasn't the basis of the authority for treatment. At the end of the day the authority for treatment was always the common law and that's the point essentially that I'm making.

ELIAS CJ:

But does it matter? There are plenty of, I'm trying to think of some examples, but I think there are plenty of examples of statutes picking up common law concepts or rights and it doesn't seem to me that acting on the legislation is not acting pursuant to the Act simply because it refers to some other source. It's adopting it.

MS COOPER:

Well one would have thought again Your Honour, if that was correct the Act could have stated that and the leave and immunity provisions could have stated that too. I suppose I come back then to the fundamental principle of interpreting those sorts of provisions that you have to look where the effect will be to deny a citizen access to the Court potentially have to look quite strictly at those provisions to say was that the actual intention of the legislation –

ELIAS CJ:

You see I know you've been driven to it but I wonder really whether the distinction is appropriately between informal patients and committed patients because it's difficult to discern the policy in that distinction and I think your argument in fact fits – has a lot more legs with the 1911 Act because the immunity in that context, both for committed patients and voluntary boarders, could well have been construed to be confined to the powers of committal and restraint. But the Act has expanded and we have to interpret the immunity in

the context of the expanded Act which is much more concerned with – which is concerned with treatment.

MS COOPER:

Yes. I think though, I guess I come back to the legislative framework and that is that the Act created a very distinct regime for committed patients and lots of protective mechanisms there for committed patients that were not available for informal patients. For example the right of review. The fact that it was, there were quite a lot of restrictive procedures to go through before one could actually be committed. So I think that the Act created a distinctive regime that applied to committed patients that was different for informal patients so they were not treated in any of the legislations as if they were identical and therefore there must have been a reason for that and I think the premise, the starting premise that we come to is that in each of the legislations, less so I think in the 1969 Act, but certainly that the treatment of an informal patient was almost always premised on consent and that is different from a committed patient because the premise of committal of a committed patient is that you may treat without consent and that continues to be the framework under the 1992 Act.

I suppose the other thing is you need to look too at the 1992 Act and where informal patients have disappeared completely, there is not one transitional provision, and one would have thought that if the intention of the 1969 Act was that informal patients were to be dealt with I suppose in a way analogous to committed patients, that there would have needed to have been transitional provisions actually specifically removing them from the 1992 Act. But there's no transitional provisions and the argument will be is that's because they'd already disappeared out from the 1969 Act by virtue of the 1972 amendments and I'll come onto that because that's a specific statutory interpretation argument.

But the issue to be made is that, is the point that the legislation has always treated informal patients and committed patients quite differently and there are much more restrictive, I suppose rights that are enforced on committed

patients as opposed to voluntary patients and therefore more protective mechanisms to make sure that they are able to have their rights upheld if they're being breached, that were not necessarily available to informal patients. One could look for example at the offence provisions. That didn't necessarily apply to an informal patient under the 1911 Act or the 1969 Act because you had to be mentally disordered for the offence provisions to kick in.

ELIAS CJ:

Not the assault ones, surely?

MS COOPER:

Yes, even the assault ones Your Honour. So if you look at the offence provisions dealt with at page 11, paragraph 37.

ELIAS CJ:

Sorry what section is it? It's towards the end, isn't it?

MS COOPER:

Yes. If you look at section 126, if you look first at section 112.

TIPPING J:

Is this of the 1969 Act?

MS COOPER:

This is, yes I've got, sorry, the 1969 Act. If we look at the – the 1911 Act was fairly similar actually, I'll look at that.

ELIAS CJ:

Well don't worry, it's really just the general point.

MS COOPER:

So if you look at the offence provisions you'll see for example in relation to striking, wounding or ill-treating, it actually had to – it only applied to a

mentally disordered person and that's the same in the Mental Health Act 1969 and similarly the sexual offence –

ELIAS CJ:

Well that's because there's no consent available.

MS COOPER:

Yes.

ELIAS CJ:

So that's the reason for that difference but I must say I'm a bit taken aback by the assault provision.

MS COOPER:

Yes.

TIPPING J:

What happened, Ms Cooper, when it all got transferred to the hospital boards? Is it possible that that step which I know you may be a bit ahead in your programme, but does that give any clue to what was meant before that happened? I'm not trying to get you onto the next leg but I'm just hypothesising, is it – can we get any guide to what all this was meant to mean in 1969 when the thing changed shortly thereafter?

MS COOPER:

Well I suppose – there are a couple of points I suppose to be made about the 1969 amendment. Of course there were still some, or two hospitals that continued to operate under the Crown.

TIPPING J:

But there is said to be a change, isn't there?

MS COOPER:

Yes, yes.

TIPPING J:

You say that even if you miss out up to the change, the position becomes better from your point of view after the change, have I got that right?

MS COOPER:

Well what – the simple proposition is that after the change in 1972, informal patients came right out of the Act.

TIPPING J:

Yes?

MS COOPER:

So they were no longer covered by the 1969 Act at all. They just came out.

TIPPING J:

So the question then becomes whether they were covered or whether the immunity so called applied to them by some other vehicle, is it?

MS COOPER:

Well the – prior to the Court of Appeal we'd been successful in the argument that the effect of the amendment in 1972 meant that informal patients just simply came out of the 1969 Act and they were then dealt with as general patients.

TIPPING J:

Yes. But then you've got the Court of Appeal coming up and saying no, that's not right, the immunity still applies?

MS COOPER:

Yes, yes so – and that was an interpretation of section 7, which I'll come onto.

TIPPING J:

But that doesn't have any bearing, in a retrospective sense, on what the 1969 provisions should be –

MS COOPER:

I think it's fair to say Sir that the 1969 Act was passed in contemplation of this transfer. It had actually been – the work in terms of the transfer had actually started in the 1960s.

TIPPING J:

I see.

MS COOPER:

And in fact –

TIPPING J:

So the simple answer is no?

MS COOPER:

No.

TIPPING J:

It doesn't have any bearing retrospectively?

MS COOPER:

No.

TIPPING J:

All right, thank you.

MS COOPER:

So I wanted to just highlight that the offence provisions, and that is an anomaly and it is a point that we've picked up, is that the offence provisions did not necessarily apply to informal or voluntary patients because of the wording, you had to be mentally disordered. And that is, I think, an issue of

concern because if the Crown's argument is successful that not able to have benefit of the offence provisions but they're also subject to the immunity and that, with respect, can't be –

TIPPING J:

Is the real point here whether the contrast between 15 and 25 is such that we should run with your argument that the authority was the arrangements rather than the Act?

MS COOPER:

Yes. Yes that's it in a nutshell Sir.

TIPPING J:

Yes. Well is there anything more that you can point to that supports that argument within the statute or outside the statute?

MS COOPER:

Well that's why I'm having a look. That's one of the arguments I think Sir is to say that those – the offence provisions I think are a pointer because they are, they do not apply in their entirety to informal patients. They only apply to a category of informal patients that were mentally disordered as well. I think the other pointer is that –

ELIAS CJ:

Well presumably that's – this is an additional offence, isn't it, and it's because of the – so it doesn't mean there isn't an offence of assault under the Crimes Act –

MS COOPER:

But the immunity provision would cover assaults Your Honour. Section 124, neither the Crown –

TIPPING J:

Well a good faith assault is a rather strange proposition.

MS COOPER:

Well if you look at subsection (1), "Neither the Crown nor any person who does any act in pursuant or intended pursuance of any of the provisions under this Act shall be under any civil or criminal liability in respect of any such act."

TIPPING J:

Yes but if there was sufficient cause, you'd get leave, surely? It's to stop these sort of wild allegations for which there are no substance, that's the purpose of it, isn't it?

MS COOPER:

Yes, that's the sole purpose of it.

ELIAS CJ:

And the offence provision is quite a wide one because it covers ill treatment.

MS COOPER:

Yes it does.

ELIAS CJ:

So it's a different provision, yes. And it's there because of the particular disability that those who are mentally disordered are under and I suppose there –

MS COOPER:

Well it was also covering neglect of course and –

ELIAS CJ:

Yes.

MS COOPER:

Because that of course was a real issue for those who were subject to mental disorder as well so it was wide – ill treatment, of course then that's wider than

a physical assault as well because that would cover issues like starving someone or locking them up, one would assume, so I think the scope of that and in fact there were some cases around that, I think the scope of that section was to widen out the criminal offences under the Crimes Act certainly. But I think the point that I'm making that while that wouldn't necessarily have applied to all informal patients, and who may otherwise of course have had, on our argument, a common law action to take in relation to that negligence or tort of assault or false imprisonment but not necessarily covered by the criminal provisions.

TIPPING J:

The section is headed protection for persons, this is 124, "Protection of Persons Acting Under Authority of the Act."

MS COOPER:

Yes.

TIPPING J:

Why would people not need protection against informal patients as opposed to compulsory patients? Is there some point that I'm missing here? It doesn't, as the Chief Justice has just suggested, it doesn't, intuitively anyway, seem logical to make that distinction?

MS COOPER:

Well I suppose then it does come Sir to the argument about whether it's, and again this is the critical wording, is whether it's an act in pursuance or intended pursuance of the Act and that's the critical issue here.

TIPPING J:

I know that's the critical issue but we've got to look to the purpose of the section, haven't we, as well as the strict linguistics of it.

MS COOPER:

The history, of course, of the legislation was to actually protect doctors who sign certificates from action. I mean the starting point of it was actually to protect doctors who were signing certificates from having claims taken against them in respect of certificates so that –

TIPPING J:

False imprisonment or something?

MS COOPER:

Yes, well yes, exactly and that was the starting premise of section 124 going into the Act. It wasn't actually premised on the basis that staff were going to be having actions taken against them for assault for example because, of course, in terms of the handbooks –

TIPPING J:

But it is not in its terms in any way limited in that sense. It doesn't simply limit it to doctors giving certificates.

MS COOPER:

No but that –

TIPPING J:

It's a section of general application.

MS COOPER:

I accept that Sir but when one looks at the history of the section, that is the reason –

TIPPING J:

That was how it started.

MS COOPER:

That was how it started, yes, and –

ELIAS CJ:

That's why I suggested that it's really the supervening changes to the scope of the Act that are the problem for your argument rather that your argument was much more powerful in relation to the 1911 Act but it applied equally, it seems to me, to committed and voluntary boarders.

MS COOPER:

I can – I understand the premise that you're acting from Your Honour. I suppose it comes down to that base of the argument of whether you accept the premise of the issue of it being pursuant to any arrangements and in fact that was actually more clearly stated in the 1969 Act than it was in the 1911 Act and that premise of course is that it was the arrangements and therefore that the treatment was on the basis of consent rather than as opposed to the authority of the Act. Therefore that brought it within the ambit of the common law rather than –

TIPPING J:

What if there were no arrangement?

MS COOPER:

What if there were no arrangements?

TIPPING J:

Yes?

MS COOPER:

Well I guess I can't contemplate a situation where there would have been no arrangements.

TIPPING J:

Well that means pursuant to their arrangements as my brother Blanchard was saying. Are you saying there's always going to be at least the barest arrangements?

MS COOPER:

Yes. I mean there must –

TIPPING J:

Will you take my son or –

MS COOPER:

Yes.

TIPPING J:

– my uncle?

MS COOPER:

Well I think it probably would have gone further than that and are you going to have the, you know, for a couple of months and I think too the other issue that is important to also stress is that the superintendent had discretion there to take informal patients and that's important as well. So they didn't have to accept them.

BLANCHARD J:

But the fact there's a discretion doesn't mean the superintendent isn't, having exercised the discretion, acting under the Act.

MS COOPER:

I accept that and that's where as I say the emphasis is really on the arrangements as being the important issue and I'll – I think –

McGRATH J:

Ms Cooper, can I just ask you this. I'm right in thinking, aren't I, that the concept of arrangements under section 15 replaced the concept of request –

MS COOPER:

Yes.

McGRATH J:

– under the earlier Act?

MS COOPER:

Yes, that's exactly right.

McGRATH J:

And you've previously had a request, which actually had to specify awareness of the potential liability to be detained.

MS COOPER:

That's right.

McGRATH J:

Now if we're looking at the term "arrangements" and the word "any arrangements", it's obviously not requiring such a prescriptive document. It doesn't have to actually be a request which was – and there doesn't have to be a statement of awareness and isn't it really intended that "arrangements" are far more flexible in the earlier prescriptive requirements?

MS COOPER:

Yes and also too I think that flows Sir with the other aspect of the change of the 1969 Act in that there was no power to detain so the 1969 Act removed that power to detain unless you invoked – of course, section 16 would give the power to detain if you were applying for a reception order but unlike the, even the 1961 amendment which gave the power to detain for 24 hours –

McGRATH J:

Became lawful to detain?

MS COOPER:

Yes.

McGRATH J:

If you had the request in the stipulated form. Just –

MS COOPER:

Yes, yes.

McGRATH J:

What I suppose I'm really putting to you is that "arrangements" seem to me to be the successor of the request, not trying to do any more than that, just as a prerequisite for the statutory provisions giving power to the superintendent to operate including the power to treat and to admit?

MS COOPER:

I accept that essentially they're the same. They're a repetition of the –

McGRATH J:

Well it's a successor concept admission.

MS COOPER:

Yes, absolutely.

McGRATH J:

And a much more flexible one.

MS COOPER:

Yes. And I think the other thing that I should probably highlight about section 15 that is important, is that it also applied to patients who were already in the hospital but whose committal status lapsed and they continued to be treated. Because one of the issues that the Crown seems to focus on is that with the amendment of the 1972 Act that admission somehow went outside of the Act but treatment stayed in the Act and the issue is that section 15 was all inclusive. It included all informal patients and that included informal patients who became informal patients when their committal status lapsed. So that's an important issue as well. The purpose of section 15 was to cover all

informal patients regardless of whether they were outpatients, inpatients and they became informal patients by virtue of their committal status lapsing. And again they still had to have their care and treatment pursuant to an arrangement so that's important as well.

McGRATH J:

The other matter I just wanted to touch on with you was whether this concept of arrangements came out of the changes in England in 1959?

MS COOPER:

It's clear I think that 1969 Act was being modelled on, to a degree, the English changes and I think –

McGRATH J:

I'm focusing in particular on the notion of arrangements for placing a request. Did that come out, I just have noted the footnotes to section 15 refer to the 1959 United Kingdom Act.

MS COOPER:

Yes I think if one – I mean there's actually not much assistance from the legislation – from the readings that are around the time but it certainly, from the limited readings that are available, it certainly – that the New Zealand legislature were aware of the amendments in the 1959 UK Act.

McGRATH J:

You're not able to tell us whether the "arrangement" word came out of the 1959 legislation?

MS COOPER:

I'm not able to tell you that Your Honour but it maybe that the Crown maybe able to assist – the Solicitor maybe able to assist in his submissions.

McGRATH J:

If it is there that might be useful to me.

MS COOPER:

Yes.

ELIAS CJ:

Now Ms Cooper it seems to me that this has been very useful because we've focused on the "in pursuance of" through the legislation history. Where are you intending to take us now? What aspects of your argument do you need to develop further?

MS COOPER:

I need to develop the argument of the case law that I want to refer to and particularly the case of *Bournewood* and the academic commentary that's around that. And I think some of the documentation that was available at the time that we say is consistent with our argument that informal patients – the source of the authority for their treatment was not in the Act itself but was under the common law. So those are essentially – and then I need to address, Your Honour, the issue of the effect of the 1972 amendment.

ELIAS CJ:

Yes, all right. Well I'm just conscious of time so I maybe moving you through that but we'll take the morning adjournment now.

COURT ADJOURNS: 11.30 AM

COURT RESUMES: 11.46 AM

ELIAS CJ:

Thank you. Ms Cooper, I think we'd be assisted by having you develop your argument on the 1972 amendment, before turning to the case law.

MS COOPER:

Right.

ELIAS CJ:

Just so that we can get all the legislative sequence in our heads.

MS COOPER:

Yes. Perhaps if I could just briefly refer – Justice McGrath asked me whether the English 1959 Act was the predecessor of the 1969 Act section 15. It just may be of some assistance, one of the articles that's in our bundle which is in volume 2 and it's at tab 41, there's an article there, Staff Protection Against Civil and Criminal Action, and that's actually got the equivalent provision 131 set out at page 334 which is the first page of that article –

McGRATH J:

Sorry which tab was that?

MS COOPER:

It's tab 41 Sir.

McGRATH J:

At page?

MS COOPER:

Page 334, moving on to 335. So the English equivalent states, "Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance arrangements..." and that's where that term has come from Sir, "...made in that behalf and without any application order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be liable to be detained." So, I think, just two quick points I wanted to make. That provision is comparable to our section 15 and I think it is a reasonable assumption to say that that seems to be the ancestor in fact of our section 15. It certainly refers to "in pursuance of" arrangements. I think the point that I make in terms of that provision is that it says that nothing in this Act shall be construed as preventing a patient who requires treatment being

admitted. So, it's reinforcing the notion that I've been talking about, that it's not unlawful. It's certainly not the source of the authority itself for the treatment but it is reinforcing that it's not unlawful to treat such a patient in a hospital.

The other point I just wanted to emphasise is that the 1969 Act, right from its outset, contemplated the transfer in terms of informal patients and the management of hospitals to health boards and as I'll develop that argument and I'll come back to it, our argument is that with the effect of the 1972 amendment, informal patients were taken right out of the ambit of the 1969 Act. Just in terms of statutory interpretation, given that that transfer was contemplated right at the outset of the 1969 Act, it's difficult to conceive why there would have been a different regime in place during that short period of the transition. Why it was that they've came right out of cover of the Act and therefore were subject to the common law once the effect was, the 1972 came there but why, given in that short period there was a different regime in place and in my submission it's consistent to say that the 1969 Act always contemplated as consistently with the argument in the 1911 Act that informal patients were, in terms of their treatment, outside of the ambit of the legislation and that simply was reflected through in the 1972 amendment and then of course in the 1992 Act where they weren't referred to at all.

Now, just in terms of the 1972 Act. That is page 10 Your Honour where I address that. Now –

TIPPING J:

Where do we find the 1972 Act in your bundle, could you –

BLANCHARD J:

It's not actually an Act.

MS COOPER:

It's an amendment. It's an amendment to the 1969 Act –

BLANCHARD J:

The amendment wasn't in 1972, was it?

MS COOPER:

Yes, to section – it was, yes, sorry. It was part of the 1969 Act but – and the reason why we've called it that, it should actually be called the effect of the 1972, when the change –

BLANCHARD J:

Isn't it just section 7 of the 1969 Act which contemplated that this would occur?

MS COOPER:

It's section 14 as well and that was amended and that's the important provision that you'll see there. Section 14 was amended.

ELIAS CJ:

Sorry, where do we find this?

MS COOPER:

It's in the case on appeal, the Mental Health Act, it's the – tab 4.

ELIAS CJ:

And it's section 14?

MS COOPER:

Section 14, yes. Now, you see that section 14 was – in the section stated that, "Nothing in this part of this Act shall apply to hospitals carried on by hospital boards or to persons admitted thereto." So, right from the outset of the Act, it was clear that if a person was being treated in a hospital board then the provisions of the Act didn't apply. In terms of the significance of that section, there were of course a number of psychiatric units that were run as adjuncts to general hospitals and the Solicitor has referred to those hospitals in his submissions and it seems likely that section 14 would have covered

those. So, of course, it's again another argument to say it's consistent then that when the rest of the psychiatric hospitals in terms of informal patients moved over to general hospitals that the same provisions applied. When the amendment came in, of course section 14 was amended and that stated, "Except as provided in section 18A of this Act, nothing in this part of this Act shall apply to hospitals carried on by area health boards or hospital boards or to persons admitted thereto."

BLANCHARD J:

I am a little confused I'm afraid. The copy that we've got has a notation which says, "Amended as from 1 April 1972 by section 3(2) of the 1972 Act and as from 1 April 1984 by section 98 of the 1983 Act to read."

MS COOPER:

Yes, that was area health boards.

BLANCHARD J:

Now, what's the version as it was in 1972?

MS COOPER:

If you look at the page back Sir, we've got all of the versions that have got that amendment, so if you look further back you'll see – it's page 11, if you look down at the bottom here, page 11 that will have the amended section 14.

ELIAS CJ:

I'm looking at the wrong volume obviously.

MS COOPER:

Oh sorry, I've got the wrong bundle. Bundle 1, tab 4.

ELIAS CJ:

Yes. The pages numbers are at the top?

MS COOPER:

Yes, they are.

BLANCHARD J:

We've got two page 129s, one of which has just the original version from 1969 –

MS COOPER:

And the page before it has got the amended version, if you see it's stuck over –

BLANCHARD J:

But that's as amended in 1983, according to the note.

MS COOPER:

As from 1 April 1972.

BLANCHARD J:

No, as from 1 April 1984.

TIPPING J:

It looks as though it was twice amended.

MS COOPER:

Yes, it's because what happened was, in 1972 it was transferred to area health boards and in 1983 area health, sorry hospital boards became area health boards. So, it needed to reflect the amendments of the legislation –

BLANCHARD J:

But what did the 1972 amendment say?

MS COOPER:

That was 18A, so you'd need to look at section 18A, that referred to section 18A.

BLANCHARD J:

How did it read, how did section 14 read in 1972?

MS COOPER:

It read, as I understand it, the same as it's read there, "Except as provided in section 18A of this Act, nothing in this part of this Act shall apply to hospitals carried on by area health boards, carried on by hospital boards, or to persons admitted thereto..."

BLANCHARD J:

With respect Ms Cooper, that can't be right, unless this annotation is wrong because this clearly says it's been amended twice. Could it be that the second amendment merely put in reference to area health boards –

MS COOPER:

Yes, that's correct Sir because in 1983 area health boards replaced hospital boards.

TIPPING J:

The text of 18A in my bundle is on the first page, 131, and it looks as though area health boards was an insertion by the second.

MS COOPER:

That's correct, yes because they were brought into effect in 1983, so that's correct Sir. Section 14 as originally amended would have stated, "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." Yes and then that was amended in 1983 when area health boards were introduced by legislation.

Looking then at section 18A, subsection (1) of that section continued the operation of part 2 of the Act in relation to patients for whom a reception order had be sought under section 16. So it was making it clear that the jurisdiction

in terms of the Act continued for those who were becoming committed patients, or whose estate was being administered under section 7. There were a limited number of people mainly from the 1911 Act brought through whose estates were being administered as mentally disordered people. Other than that, the Act no longer applied to informal patients at all, that's the effect of that amendment.

BLANCHARD J:

The part of the Act didn't apply?

MS COOPER:

That part of the Act and that of course Sir, is the part of the Act relating to informal patients and the admission, the power to – whatever we describe that. So, informal patients in a sense Sir and the simple argument is that as a result of that amendment, informal patients were simply removed from the Act. The only context in which they became subject to the Act again was when they were caught by section 16 and that of course relied to the application for a reception order.

TIPPING J:

Just before you move on, 18A(3).

MS COOPER:

Yes.

TIPPING J:

Is that close to the heart of this, "Nothing in section 14, 15 or 18, shall limit or affect the discretion of an area health board or of a hospital board to admit any person to a hospital carried on by it." In other words, they still had that discretion.

MS COOPER:

Yes.

TIPPING J:

But they weren't subject to what you might call the parameters of the earlier sections but they still could – the legislation still authorised them to take people in.

MS COOPER:

I think, as I understand that section, again it's continuing to repeat the permissive nature of the legislation –

TIPPING J:

So, we're back in to that same point. Nothing really has changed, has it?

MS COOPER:

Well, I think if one looks at that, the combined – section 14 clearly stated and we come back to that, is that section 14 was the starting premises but the Act, certainly for informal patients, didn't apply to those in hospitals run by hospital boards and, as I say, there already would have been a category of those patients in hospitals –

TIPPING J:

They may not have been called it but clearly it was lawful and hospital boards et cetera were authorised to admit any person to a hospital carried on by it, including psychiatric hospitals.

MS COOPER:

Yes.

TIPPING J:

So, what has changed, other than the getting rid of, if you like, the more prescriptive parts of section 15? It just gave them a general discretion, it wasn't so precisely spelt out but surely it was still the same effect?

MS COOPER:

Well, no because I think the issue there Sir is that the power then to – the discretion to admit then was a general power to admit –

TIPPING J:

But you don't have the arrangements argument under this formulation?

MS COOPER:

I think it was – certainly my understanding of section 18(3), is that it did no more than simply confirm that area health boards, or hospital boards as it was, had a discretion to admit, as they would have had a discretion to admit any general patient and that's as far as it went. But that in terms of the issue of whether the Act covered this group of patients, that the purpose of the sections was to actually remove those patients from the ambit of cover of this Act. Therefore the issue of treatment became subject to the general hospital provisions.

WILSON J:

On that argument, why didn't section 18A(3), completely exclude section 15 in its operation to informal patients at hospitals being run by the health boards?

MS COOPER:

It's a good question. I'm going to reflect on the answer to that. I have to accept that on its face, it's a curious provision that doesn't seem to make sense of the earlier effect of section 14 or of section 18A.

TIPPING J:

It's a facet of its patchwork sort of style of drafting we have to put up with in this country.

MS COOPER:

Yes, yes, I'd agree because as I say, I think what the effect of those provisions was intended to be was to give effect to section 14 as it was already stated and that was that nothing in that part of the Act, in other words, the provisions relating to informal patients weren't covered if you were in a

hospital run by a hospital board. My understanding certainly, and that's the argument that's been accepted in the lower Courts other than the Court of Appeal, is that the effect of the amendment to section 14 and 18A was to simply acknowledge that by that stage all patients, other than those in Lake Alice and Queen Mary, had actually been transferred to hospitals run by hospital boards and to give effect to section 14 –

TIPPING J:

But isn't the reality this, that previously they had a discretion, or the superintendent had a discretion, albeit legislatively constrained in certain ways?

MS COOPER:

Yes.

TIPPING J:

All that has happened, in effect, is that they've got the same discretion but without constraints that otherwise seem to apply. It is a rather odd way of doing it but in substance, isn't that what's happened?

MS COOPER:

I think the curious issue that, and that's the issue that I'm grappling with, is the reason why sections 16 and 17 have been omitted and that's clearly because they clearly stayed within the ambit of the Act –

TIPPING J:

Well, they were reception.

MS COOPER:

They were the exceptions.

TIPPING J:

Yes.

MS COOPER:

As I say, I think my reading of that section is that it does nothing more than confirm the ongoing discretion to admit and that's similar to the general hospital power.

TIPPING J:

Then we're back to the same argument, with you missing the arrangement point.

MS COOPER:

Except that section – it's still got to be read subject to section 15. I mean, section 15 is still there.

TIPPING J:

No, nothing in it limits or effects the discretion, so there don't have to be any arrangements. So your point about arrangements is made rather more difficult under this formulation.

MS COOPER:

Except Sir I think then one has to look then at what happened with the 1992 Act and say that –

TIPPING J:

Well, all right.

MS COOPER:

– with the 1992 Act informal patients disappeared completely, they weren't even –

TIPPING J:

But aren't we concerned only with the 1969 and the 1972, what we're calling the 1972?

MS COOPER:

Yes, yes you are but I think the importance of the 1992 Act is that if, if as Your Honour is putting to me, that the effect was to essentially bring back in cover of the Mental Health Act 1969 through 18A(3), then one would have expected that there would have been transitional provisions in the 1992 Act that actually stated that this legislation shall no longer have any application to informal patients. But in fact there was no transitional provision at all, informal patients simply disappeared out of the 1992 Act. In my submission, the only premise on which that can have happened is because it was clearly understood that the effect of this amendment was to completely remove informal patients from the ambit of the legislation, in any event, so there was no need for transitional provisions because they were already gone. They had already been taken out and they were already treated in all ways as if they were general patients.

TIPPING J:

What would you call a person admitted under 18A(3), who wasn't within any other classification?

MS COOPER:

Well, they would still be an informal patient.

TIPPING J:

I sympathise with you Ms Cooper because this is mind-bendingly sort of peculiar –

MS COOPER:

Yes, it is.

TIPPING J:

– but I'm trying to get to the substance of it.

MS COOPER:

I understand it and I think Sir again, one has to – I suppose that's, whereas I say, that the subsequent legislation has to be of some assistance in guiding the Court in terms of the interpretation of this particular amendment and that is that –

TIPPING J:

Your point is that there was no reference in that to informal patients?

MS COOPER:

No, at all, no transitional provisions and therefore I think it's able to be reasoned from that, that there were no transitional provisions necessary because they had already disappeared from the legislation. Otherwise there would have needed to have been some transitional provisions to say, there are no longer informal patients, they shall be discharged et cetera but there was nothing at all. As I say, other than the limited contexts in which informal patients are still able to be detained, as has been in every Act, and I suppose too there are other references to informal patients being able to be visited by district inspectors and being able to be the subject of a judicial inquiry. I mean, there are some aspects in which all of the legislation is actually consistent, that is in respect of informal patients and they are protective or bureaucratic provisions.

I think actually there is another point that I should also highlight too and that is, one needs to look in the 1969 Act at the definition of a patient. If you look at section 2, you will see there that, of an informal patient, you'll see there that an informal patient was defined in the Act as, "...receiving care and treatment in a psychiatric hospital carried on by the Crown" and that's an important part of the definition.

TIPPING J:

Was that definition revoked?

ELIAS CJ:

Which definition section are we looking at?

MS COOPER:

You're looking at the 1969 Act Ma'am. Section 2.

ELIAS CJ:

Patient?

MS COOPER:

Yes, informal patient Ma'am.

ELIAS CJ:

Oh informal patient, sorry.

MS COOPER:

Yes.

TIPPING J:

Was that definition revoked on the coming into force of the '72 amendment?

MS COOPER:

There's certainly nothing in the legislation that we have that shows that provision was revoked so it remained in force so an informal patient could actually only be a patient in a hospital run by the Crown –

TIPPING J:

Under section 18A(3) I would have thought.

MS COOPER:

Well, I think the issue there though Sir is that the important words in terms of an informal patient is that they had to be in a psychiatric hospital carried on by the Crown and of course after the amendment they were in psychiatric

hospitals carried on by hospital boards so they were not by definition informal patients any longer in terms of the Act.

ELIAS CJ:

Won't they be licensed institutions?

TIPPING J:

Or a licensed institution?

MS COOPER:

Or licensed institutions, yes.

ELIAS CJ:

Well surely the Crown – the regional boards or whatever they are, the area health boards are licensed institutions aren't they?

MS COOPER:

Well no they – because they were licensed institutions under the 1969 Act and they were contemplating like boarding houses and –

ELIAS CJ:

Oh yes, I realise that but –

TIPPING J:

Licensed under section 9.

MS COOPER:

Yes.

McGRATH J:

This is places like Ashburn Hall and that –

MS COOPER:

Yes.

McGRATH J:

– originally.

MS COOPER:

Yes, exactly.

McGRATH J:

But you can't really say that the definition was intended to confine to the Crown, can you?

MS COOPER:

Oh yes though –

McGRATH J:

When the Act was passed it obviously was intended to cover all those who were conducting psychiatric hospitals?

MS COOPER:

Well no I don't think that is correct Sir because if you look at section 14 that also confined the definition to informal patients as being not – the Act didn't cover those who were in hospitals that were run by hospital boards so that's completely consistent with section 14. I think that's the whole point of this legislation is that it was confining the ambit in terms of informal patients to those who were in hospitals run by the Crown and once those hospitals were transferred out of the control of the Crown, then informal patients were no longer covered and that I think is, as I say, it's consistent with section 14 and it's consistent with section 2, that wasn't revoked, and although I accept that 18A(3) is problematic I think then if one – you have to come back to the statutory definition of what an informal patient is and they are taken out of that definition by virtue of –

TIPPING J:

But if they are in there lawfully under 18A(3), never mind what you call them, surely their treatment is authorised by 18A(3)?

MS COOPER:

But if they are not – if they're not an informal patient and they're not, because of the – by virtue of the definition, they're not a committed patient and the only committed patients were those in contemplation under section 16 where a reception order was being applied for, then the operation of the Act took them outside of the ambit of the Act.

TIPPING J:

Are they in a sort of no man's land?

MS COOPER:

Well no I, as I say, they come under the same as any other general patient and that is that they were admitted as general patients and as I say completely consistent with section 14, which says that it doesn't apply to any informal patients admitted to a hospital run by a hospital board so it is all consistent.

Section 14 was there at the outset and that, as I say, made it quite clear that the ambit of the Act was not to apply to informal patients in hospitals that were not run by the Crown. In my submission, Your Honours, that is the effect of section 18A and is consistent with section 14 and it's certainly consistent with the definition of an informal patient in section 2.

BLANCHARD J:

So is your argument that after the 1st of April 1972, if somebody was admitted in circumstances where they would previously have been an informal patient, and admitted now to a psychiatric hospital carried on by a hospital board, they simply go in as a general patient under the Hospitals Act –

MS COOPER:

Yes.

BLANCHARD J:

And their treatment is also under the Hospitals Act?

MS COOPER:

They're – yes.

BLANCHARD J:

What aspects of the Mental Health Act would continue to apply to them?

MS COOPER:

None. Prior to that amendment, there were some provisions that would have applied to them and as I say they were the machinery provisions but after that they, they would have just been subject to the general provisions.

TIPPING J:

So they go in just as if they had a broken leg?

MS COOPER:

Sorry, section 16 applied to them obviously, yes.

TIPPING J:

Yes, well that's right. There's a bit more.

MS COOPER:

Well section 16 and 17 apply to them and that was clearly stated in the Act to apply, to continue to apply to informal patients. But other than that, yes, I say they went in and were treated as general patients, as were patients who were already being treated in psychiatric units that were run by hospital boards prior to that amendment in 1972. Of course that's the position now under the 1992 Act. They are treated, informal patients are treated in all respects now as general patients. There is no statutory regime that applies to them. They, as I

say, they're simply not referred to in the 1992 Act at all and again in terms of interpreting this Act and the amendments, the 1992 Act is of significance because it's a help, I think it's an aid to –

ELIAS CJ:

Because there's no transitional provision such as would have been required if your argument was not correct?

MS COOPER:

Yes. But also too, just to say that the absence of informal patients from the 1992 Act also reinforces the argument that they could be and – in terms of the argument could be and are now treated as general patients and there's no – certainly that was in contemplation and we say that's what happened with the amendment in 1972. Well of course we say that they were always treated as general patients in that sense because they were subject to the common law and that essentially has continued throughout.

Is there any more assistance I can give in relation to the 1972 Act?

ELIAS CJ:

No I think that's helpful, thank you.

MS COOPER:

Just in –

ELIAS CJ:

On the development of your further argument, I'm just conscious of the time.

MS COOPER:

Yes.

ELIAS CJ:

You have developed your reference to the authorities at some length in your written submissions which we've read so I think you really need only to touch

on things that are, particularly in the light of the discussion we've had, you think help support your argument.

MS COOPER:

Yes, thank you Your Honour. I think essentially the argument is that the academic writing in terms of this area is largely supportive of the proposition that I'm arguing and that is that the source of the authority for treatment of informal patients is based in the common law and is outside – is not an act in pursuance or intended pursuance of the Act.

I start, and I've referred to the case of *Bournewood* which is a House of Lords case. That of course dealt with an incapacitated informal patient. The House of Lords had to consider the equivalent immunity provision there which didn't apply and then they had to consider the source of the authority for the treatment and in that case they were quite clear that the source of the authority for treatment was the common law and they based their decision on the common law. So say that that case is on point, it's not directly on point but it is of assistance in terms of that authority.

Then I refer Your Honours to the academic writing that's been around the *Bournewood* case in particular. I should stress that of course the English legislation is very similar to the New Zealand legislation so I think we certainly have to be guided by the academic writing in England and also in terms of the English case law interpretation. I think the other case law I simply highlight is that, there isn't anything directly on point, but the other cases that have been dealt with in this area certainly do emphasise that the interpretation of the provisions has been – because patients have been committed and there's always been an acknowledgement in the cases that one would need to look differently at informal patients. The articles that I've referred to should also include the articles in the supplementary bundle that was provided and particularly the articles that are written – well in fact they're in the bundles 2, 3, 4 and 5. John Dawson's written articles that address the New Zealand context and the application of that within the New Zealand context and so of course that will be informative and of assistance to Your Honours. I think the

proposition is, is that the academic writing does support the argument for which I'm contending and that is that the source of authority for treating informal patients is derived from the common law and not from the statute and that develops that argument quite well.

ELIAS CJ:

So, that is all directed at the in pursuance of argument, is it?

MS COOPER:

Yes, yes and I suppose it's also addressing really I suppose the source of authority for treatment of informal patients and whether that, if one looks at the statutory provisions, that actually provides the source of authority and the academic view is that it is derived from the common law.

Unless Your Honours actually have – I suppose there is one case directionally on point and that's *Runighian*, a Crown county case. That was a case that relied on *Pountney v Griffiths*, of course House of Lords noted that in the House of Lords that the fact that the patient had been a committed patient was strongly relied on by the House of Lords in terms of saying that the Act covered, the immunity in the Act covered that, and distinguished that for an informal patient and decided that the Act didn't apply. I've simply highlighted immunity provisions generally and also emphasised from a more human rights perspective I suppose, that any legislation that's interfering with the rights of access to the Courts needs to be strictly interpreted by the Courts and interpreted on that basis.

Just in terms of some of the documents again and I'll leave Your Honours to read them but the emphasis is that the documents that were being drafted as legal advice at the time support, in my view, the contention on behalf of the appellants that informal patients were certainly treated quite differently from committed patients in terms of what the basis of the right to treat was. There was a particular document which is referred to in paragraphs 83 to 85 of my submissions and that is clearly pointing out that for committed patients the source of that authority was section 25 which is the debate that we had before

and that was different in the case of informal patients. I think it's important to say that even from the documentation that was being generated at the time, that is consistent with the approach that's being adopted by me that for informal patients the source of the treatment was the common law was consent.

I suppose I will also highlight that my learned friend the Solicitor, when he was writing on the issue, agreed that in terms of informal patients under the 1969 Act that for all intents and purposes they had the same status as patients in non-psychiatric hospitals and institutions which is the premise I've been arguing to Your Honours. That was in his text which is cited at paragraph 89 of my submissions.

BLANCHARD J:

It's amazing the things that come back to haunt you.

MS COOPER:

Yes, it is indeed.

BLANCHARD J:

Fortunately he's not dead.

TIPPING J:

I'm not sure that the learned author is quite saying what you are wanting him to have been saying but never mind, I don't want to prolong the agony.

MS COOPER:

Well, I think those Sir, in terms of if you're saying that they were treated as general patients which is the point that I've making, that that is consistent with the argument that I've been running Sir.

TIPPING J:

Yes, yes.

MS COOPER:

I would highly recommend the Jones article which I think is probably the best analysis of the provisions in terms of the application of the leave and immunity provisions and that application. I think that's probably the most academic analysis. It's in the English context but it is, I think it's a useful analysis and what he's saying is that if the mental health legislation is to apply at all to informal patients it most be within the strict confines of the Act. I don't argue with that, I think that's sensible. For example, as Your Honour put to me, the power to detain, I think that has to be within the confines of the Act. Things that are specifically stated in the Act as applying to informal patients, I think I have to concede that they would be an act in pursuant but anything else is outside of that. I think the other thing that he pointed out was that the onus then would be on the defendant to show that –

TIPPING J:

Is that an argument that reduces to it must be express, it can't be by implication?

MS COOPER:

Yes, yes and I think, as I say, I think that's actually a very good exposition of the whole argument really and, as I say, puts the onus then on the defendant to show that it was actually an act in pursuance or intended pursuance. My final comment, I suppose on that, is that in the pleadings in none of the defences that have been filed would an issue arise of intended pursuance, for example, because all of the pleadings are a bare denial of the facts, or say there is no knowledge, and to rely on intended pursuance of course you'd have to plead a positive honest belief. Whereas the pleadings – the defence at the moment simply says, has no knowledge or denies the facts. So, that sort of argument is not raised on the pleadings on the defence to date.

Unless I can help Your Honours further, those are my submissions.

ELIAS CJ:

No, thank you Ms Cooper, that's been very helpful. Mr Chapman.

MR CHAPMAN:

Could you just give me a moment Your Honour.

ELIAS CJ:

Yes, of course.

MR CHAPMAN:

Now, if Your Honours please, my learned friend has covered quite a lot of the ground which is also covered in my submissions. I wonder if it would be helpful, while avoiding repeating as far I can what she has already said, if I work backwards by starting with the 1969 Act and in particular the 1972 transfer of control to the hospital boards. As Justice Tipping said, this is a patchwork but in my submission it is possible to make coherent sense of the legislation.

The starting point perhaps with that is that until 1969 there were two distinct streams of health care. There was the general hospital set up under the Hospitals Act 1957 and the 1908 predecessor to that and there was the mental health regime covered by the successive Lunatics Acts and Mental Health Acts. It is clear from the parliamentary material, which Your Honours have, that the intention was to merge those as far as possible with the transfer of control to the hospital boards. It appears in a number of places in the parliamentary debates that the intention was, as far as possible, to bring mental health patients on to the same footing as general hospital patients and to remove the distinctions between them. With that background in mind, one can see that the purpose of the changes in 1969 which came into force, as my friend has said in 1972, can be understood.

If I can perhaps ask Your Honours to start with section 7 of the 1969 Act. That's to be found under tab 4 of volume 1 of the appellant's bundle and it's on page 126 and 127 of the statute. It's apparent, in my submission, from section 7 particularly, that what was intended was an integration of psychiatric and general hospital services and one gets that, among other ways, from

subsections (6) and (7) and also subsection (8). So, if one reads those together, in my submission, it becomes clear that what was in mind was that it would be possible for a hospital to run, both a general hospital and a psychiatric hospital under the same roof, so to speak, or as part of the same institution. That, of course, in fact is what happened in a number of cases so that, for example, there has been for many years a psychiatric unit at Wellington Hospital, there is one at Palmerston North and in other places as well and I don't need to give Your Honours details, but that really follows on from section 7.

Now, when one considers that in conjunction with the definition of "informal patient" to which my friend referred you in section 2, which takes, on the face of it, limits informal patients to people admitted to a Crown controlled psychiatric hospital and section 14. The result, in my submission, is that once control of a hospital passed to a hospital board, informal patients, so to speak, disappeared off the map, they simply didn't exist anymore, they were – it's perfectly true that they were styled informal patients for convenience, but they were, in all respects, in the same position as general hospital patients and in that context, it's possible to make sense of section 16 and section 18A. Now, section 16 is the one which empowers the hospital to detain for the purpose of applying for a reception order and it's significant, in my submission, it doesn't talk about patients, it talks about any person admitted to the hospital. So the person to whom section 16 applies might have started off as a psychiatric patient or they might have started as a general hospital patient. In either case, section 16 can be brought into play. In the same way, one can start to make sense of section 18A, because subsection (3) of section 18A which was, I think the point of the question that Justice Wilson raised, in my submission simply declares that there is nothing to interfere with the discretion of a hospital of any kind to admit any kind of patient, and that's all it means.

ELIAS CJ:

To admit any person.

MR CHAPMAN:

Yes.

ELIAS CJ:

I'm just picking up on your point that it doesn't refer to patient.

MR CHAPMAN:

Yes, well what I suggest that really means is that it's there out of caution in case it should be thought that part 2 otherwise had some effect on the ability of a hospital to admit a general patient and if it's understood in that way, in my submission, that's all it means.

ELIAS CJ:

So it's neutral is it?

MR CHAPMAN:

Yes, exactly so. So the net result of all that, if I can try and knit it all together, is simply to equate what people who were formerly informal patients in every way were general hospital patients and the Act from the time of – from 1972, simply ceased to apply to them because there was nothing left in the Act that related to them in that way. My submission is that –

ELIAS CJ:

Sorry, are you saying the Mental Health Act ceased to apply?

MR CHAPMAN:

Yes, ceased to apply to them because there's, apart from part 2 –

ELIAS CJ:

Why wasn't it, part 2 repealed then?

MR CHAPMAN:

Well the most obvious answer, I suppose, is section 14, it wasn't necessary.

ELIAS CJ:

Yes.

BLANCHARD J:

Presumably there could still be some informal patients being admitted to Crown hospitals?

MR CHAPMAN:

Yes, yes of course.

BLANCHARD J:

So they would need it for that.

ELIAS CJ:

Yes that's right, it was going to wither away.

MR CHAPMAN:

Yes, and that continued until 1986. But in my submission, the restricted definition of "informal patient" in section 2 together with section 14 really admits no other sensible interpretation. If I may anticipate what I expect my learned friend the Solicitor-General to be saying, as I understand the Crown's argument, it is that despite all that, informal patients are still covered by the Act, or were still covered by the Act because of the effect of section 7 and the Crown's argument, I think, is that section 7 authorised the doing of everything that was necessary to operate a psychiatric hospital and seeing that treating people who were formerly styled informal patients was part of operating a psychiatric hospital, they are brought back within the scope of the Act in that way, a very indirect way, if I may say so, in the light of the very clear wording of section 14 and the definition of informal patient.

In my submission, there are serious logical difficulties with that. For one thing, there would have been no reliable way after 1972 of knowing whether a particular person was being treated as a psychiatric patient or a general patient or a mixture of both, so that if someone was admitted for general

surgery, let us say, and it became clear in the course of their treatment that they were suffering from depression, the question to ask then is if they were then treated with anti-depressant drugs, for example, were they then suddenly transferred to the jurisdiction, so to speak, of the Mental Health Act or does it depend on whether they were being treated by a psychiatrist or a surgeon or does it depend on whether they were in the psychiatric ward or a general ward or what? And the question becomes particularly acute, I suggest, when you're dealing with a patient whose condition may have been on the borderline between a mental health issue and some other kind of medical issue. One can give some examples of that –

ELIAS CJ:

Does this mean that the thrust of the changes is to require formal, what it's now called, committal or –

MR CHAPMAN:

Yes, committed patients.

ELIAS CJ:

Yes, formal steps to be taken to vis-à-vis the status of particular patients –

MR CHAPMAN:

Yes.

ELIAS CJ:

– before the Mental Health Act applies to them?

MR CHAPMAN:

Correct, exactly so and for everyone else they could simply arrive at the hospital reception area and asked to be admitted, whether they were suffering from a psychiatric illness or a broken leg and from that point on, there was no distinction between the two, that's the point.

TIPPING J:

Your point, put rather vividly, is that if they were mistreated it is hard to say whether they were being mistreated as a broken leg patient or as a psychiatric patient.

MR CHAPMAN:

Quite so, quite so and indeed, one can see over the years as boundaries between what might be called general health care and mental health care have shifted, there will have been some conditions where it's not possible to be sure which side of the boundary they were on. The obvious example is epilepsy because in the 1911 Act epilepsy was one of the conditions regarded as satisfying the definition of mental defective. No one would suggest that now and at some point in time, no doubt that condition hovered on or crossed the borderline between the two, at least in medical thinking. I give you that example simple because it highlights the point that Your Honour has just made.

WILSON J:

Mr Chapman, is the consequence of your argument, in what I'll term the second issue, that the Crown has the section 124 protection in respect of informal patients at Lake Alice and Queen Mary, that area health boards did not have similar protection in respect of informal patients in their psychiatric units?

MR CHAPMAN:

That's correct, yes. That of course is assuming, perhaps I should just qualify that. That's of course assuming that Your Honours don't accept the argument about the earlier position, yes.

WILSON J:

Exactly, that's why I refer to the second issue.

McGRATH J:

Why would the legislation have that purpose, or do you think it's perhaps an accidental consequence?

MR CHAPMAN:

No, I suspect it's not an accidental consequence Your Honour. It's a manifestation of the determination to equate mental health and general health patients as much as possible. With the blurring of boundaries, that I mentioned a moment ago, it would have been in some cases almost impossible, one would have thought, to be sure which side of the line people fell and consequently whether the leave and immunity provisions applied or didn't apply.

BLANCHARD J:

Why weren't they removed then for others? I suppose you will say because they weren't in general hospitals?

MR CHAPMAN:

Yes, yes.

McGRATH J:

Yes.

TIPPING J:

It's really a demarcation problem that you're highlighting. In my brother Wilson's example, which I must say I find rather troubling, there's no such demarcation because they are in a specifically dedicated hospital. That has to be the rationale for allowing them to have the immunity and not the other ones.

MR CHAPMAN:

No, perhaps I didn't make the point sufficiently clear. I'm not suggesting that the leave and immunity provisions cease to apply only to people who are in general or mixed hospitals. What I am saying is that the fact that that was the position highlights the point that it ceased to apply to informal patients altogether, whichever hospital they were in.

TIPPING J:

So an informal patient in Lake Alice would not have the immunity?

ELIAS CJ:

The staff wouldn't have the immunity.

TIPPING J:

The staff, sorry, the staff wouldn't have the immunity.

MR CHAPMAN:

Of course Lake Alice would have still been under Crown control in 1972. So informal patients, in terms of the Act could still be admitted to Lake Alice for some years after that and so the leave and immunity provisions ceased to apply to them, only if Your Honours accept what Justice Wilson has called in the first argument.

ELIAS CJ:

I'm getting confused. Tell me quickly, the first and the second arguments because we moved straight from one to the other. The first is a very bold argument.

TIPPING J:

It's the first period, isn't it?

WILSON J:

It's really a temporal distinction.

ELIAS CJ:

Yes, yes.

MR CHAPMAN:

The first argument is that the leave and immunity provisions never applied to informal patients.

ELIAS CJ:

Yes, yes.

MR CHAPMAN:

The second argument is, if that's wrong then they didn't apply from 1972 on.

BLANCHARD J:

Except in relation to Lake Alice and Queen Mary.

TIPPING J:

Which seems on its face to be a somewhat strange outcome.

MR CHAPMAN:

Well, you've raised –

TIPPING J:

Staff in one or two institutions have the protection, of which section 124 speaks, and the others don't.

MR CHAPMAN:

One can look at it that way but there was plainly a deliberate decision by the Crown to retain control of Lake Alice and Queen Mary. The reasons I think are not clearly before you and one can speculate that the purpose of the immunity, with leave and immunity originally, was to protect the Crown although of course it goes further than that. While I take Your Honour's point, it's difficult to understand any cogent reason, if it's right, for the quite sweeping terms of section 14 and the limited definition of informal patient in section 2.

TIPPING J:

I think 124 is designed to protect more than the Crown.

MR CHAPMAN:

I accept that, I accept that.

WILSON J:

On that point Mr Chapman, from 1972 on did the health boards have the benefit of the immunity in respect of committed patients in their psychiatric units?

MR CHAPMAN:

Yes, yes.

WILSON J:

So you've got a further demarcation issue there.

MR CHAPMAN:

Yes but if you – it really brings us back to the point that the intention seems to have been to equate informal patients, as they were called before 1972, with every other kind of patient and if that's the intention, then general hospital patients didn't have the leave and immunity problems so why should the others.

TIPPING J:

But there's nothing to suggest that this issue was directly addressed, is there, that they made a deliberate choice of the consequence that you're arguing for?

MR CHAPMAN:

There's nothing in the parliamentary debates that I can see, no. I'm not aware of anything in any of the departmental literature or anything of that kind that really deals with it directly at all.

TIPPING J:

It's certainly not there in the Act. It's very hard to discern any clear express intention to have the result that's now being suggested. That may or may not help you but I'm just, as a matter of fact.

MR CHAPMAN:

There's certainly nothing that says it in so many words, of course. If it had been intended to retain the immunity for hospital board patients informal, if I can put that in inverted commas, "hospital board patients", it would have been very simple to say so and –

TIPPING J:

That's why I say, the argument doesn't necessarily go against, it can go both ways.

MR CHAPMAN:

Yes, yes, quite.

ELIAS CJ:

The demarcation difficulty of course may push one to a more restricted interpretation of the immunity, tying it back to the restraint and confinement.

MR CHAPMAN:

Possibly.

ELIAS CJ:

Because then there wouldn't really be a demarcation problem.

MR CHAPMAN:

That would certainly be one way of solving it. It's a, perhaps if I can digress for a moment, it's perhaps of some interest that all of the case law about the leave and immunity provisions in this country up to I think 1992, so that's the first 70 years or so of the Mental Health Act, is to do with people who are aggrieved by the committal procedure.

ELIAS CJ:

Yes.

MR CHAPMAN:

The first sign of anything else is the decision in *Leeks v McEnroe* which is not in the bundle I'm afraid. It's not directly relevant but it's of historical interest because that was the first occasion on which at least there's any accessible judgment in relation to a case where a patient was seeking to sue because of mistreatment as a patient. I don't place any particular relevance –

ELIAS CJ:

So when was that, roughly?

MR CHAPMAN:

I think the decision in fact was 1994. It's a decision of Master Thompson, not reported, and it seems to have turned on its particular facts.

ELIAS CJ:

Because one of the things that troubles me about all of this is the shortness of the leave opportunity which does make sense if the immunity is directed at the committal status but it doesn't really make sense if it's concerned with mistreatment.

MR CHAPMAN:

Yes, well, quite and indeed one of the problems that faces people who are in the position of the present appellants is that the time limit might well have expired long before they had any real opportunity to do anything about it. It's a very, it's a very short time limit. As my learned friend said historically the reason given, at least in the parliamentary debates, for introducing that was to protect doctors who were said to be refusing to certify patients for committal if they didn't get some protection and that seems to have followed on in this country from a similar situation in the United Kingdom.

ELIAS CJ:

And that is at the time when the committal process was transferred to the medical profession, was it, from the judiciary?

MR CHAPMAN:

No it's sometime after that. In this country the committal process first becomes reliant on medical certificates prior to 1911 and I'm sorry I don't recall, it's in one of the Lunacy Acts as I recall it and probably goes back to possibly 1866 which is the – but, so that's been around for quite a long time but the introduction of the leave and immunity provisions in their present form only dates from 1935.

ELIAS CJ:

Yes, following the English legislation.

MR CHAPMAN:

Yes which was enacted I think in 1930 and the – if one – again, I don't think it's in the bundle but the two provisions are very similar –

ELIAS CJ:

Yes.

MR CHAPMAN:

And in both cases, I think, certainly in the New Zealand case, the effect was to reverse the onus, so to speak, because prior to 1935 and the original 1911 Act the requirement was put differently. It was simply you could bring your proceeding without any leave but were liable to be struck out if you couldn't, once the defendant applied to strike out, satisfy the Court that there were –

ELIAS CJ:

I see.

MR CHAPMAN:

– reasonable grounds for proceeding.

McGRATH J:

It was a stay, a provision to seek a stay.

MR CHAPMAN:

Yes, I think that's how it was phrased, yes. And evidently it was thought in 1935 that that didn't give enough protection. Since then, as Your Honours know, the provisions have been spoken of a number of times as they're to give protection to staff from unjustified or unwarranted claim by patients. Perhaps while I'm on that point I can just deal with something that arises from it because the Crown's argument, as I understand it, is that it applies to anything to do with the operation of a psychiatric hospital and so anybody, on that construction, anybody who wants to bring any kind of claim of any sort which arises from the operation of a psychiatric hospital, requires leave to start with and it's very easy, in my submission, to postulate a case where that would be quite unworkable.

For example, if one takes the case of a nurse who has had what he or she thinks is an unwanted deduction from his or her pay. Now presumably somewhere the pay clerk has come to the conclusion that it's appropriate to make the deduction. That plainly falls within the general operation of a psychiatric hospital but one would hesitate to suggest that the nurse who wants to sue for the arrears of pay or bring a personal grievance or whatever remedy is sought, would have to get leave and if it within six months –

TIPPING J:

Well doesn't the Crown, at least implicitly, limit the width of that proposition to something to do with care and treatment of patients. I mean otherwise, as you say, it becomes an absurdity.

MR CHAPMAN:

Well quite but if – once one starts to do that, then one has to accept that there are some things to do with the operation of the psychiatric hospital that aren't covered and my learned friend will no doubt tell you if I've misunderstood him but as I understand the argument he intends to address to you it is that notwithstanding section 14, section 7 brings informal patients back into the fold of the Act, so to speak, indirectly because it authorises a carrying on of

psychiatric hospitals and therefore anything that is done for that reason is pursuant to the Act and therefore caught by section 124.

Now, if that argument is correct, then the example that I gave a moment ago follows. If one starts to limit it, then the, in my submission first of all, the respondent's argument about informal patients post 1972 can't succeed, but secondly it gives some cover to the point Her Honour the Chief Justice raised a short time ago about whether one has to think about section 124 really in terms of restraint and committal and matters of that kind. Now it maybe that Your Honours don't have to decide that in the context of this appeal but it's clear, I submit, however wide it is, it can't include just everything that's done to run a psychiatric hospital.

McGRATH J:

Mr Chapman, as I understand it's the section – the 1935 provision was, as you say, modelled on the 1930 –

MR CHAPMAN:

Yes.

McGRATH J:

– provision United Kingdom, but that was re-enacted in 1959 following consideration by a Royal Commission.

MR CHAPMAN:

Yes.

McGRATH J:

I'm wondering is there anything in that Royal Commission's report that gives some clarification as to the scope of the provision?

MR CHAPMAN:

Not, not really. There is certainly some English, United Kingdom writing about the scope of it afterwards, and some of that is, that's in the bundle, in the supplementary bundle and I can refer Your Honours to –

McGRATH J:

I'm just interested in the Royal Commission –

MR CHAPMAN:

No.

McGRATH J:

– as to whether that – because it obviously gave some consideration to it but it didn't go into the scope I take it?

MR CHAPMAN:

No, ah, I would need to check. There is certainly – there was a review of the 1959 Act which raised the question about whether the English section applied to informal patients without, I think, attempting to answer.

McGRATH J:

I think that the – I was more concerned with an enquiry prior to 1959.

MR CHAPMAN:

No, not as far as I know.

McGRATH J:

Thank you.

MR CHAPMAN:

Now unless there is any point in relation to the 1972 argument, if I can put it that way, that I can help Your Honours with I intend to move onto something else.

ELIAS CJ:

We'll take the adjournment now. Thank you.

COURT ADJOURNS: 12.59 PM

COURT RESUMES: 2.17 PM

ELIAS CJ:

Yes, Mr Chapman.

MR CHAPMAN:

Yes, thank you Your Honour. Having said before the adjournment that I had finished with the 1972 point, I wonder if I might recant very briefly and return to just one matter that I overlooked and that is to do with section 7 of the 1969 Act, it's under tab 4 in volume 1 of the bundle, page 126. I simply wanted to draw attention to the point that section 7(1) is introduced by the words "Subject to this Act" making it clear that the carrying on of a psychiatric hospital by whoever it may be is subject to the other provisions of the Act, which, in my submission, makes it absolutely clear that, to the extent that there may be a perceived conflict, section 14 prevails over section 7.

Now, having dealt with that, I wonder if I might perhaps to some extent continue my theme of working backwards in the interests of getting through the material as rapidly as I can and I don't want to deal with my submission, my written submissions at all, but to simply pick out a relatively small number of points that may assist Your Honours. I wonder if I might start by discussing briefly section 131 of the UK Act, which was touched on this morning and which can, the text of it can be found in the article by Dimond in volume 2 of the bundle under tab 41. The text of it is set out at the foot of page 334 and the first two or three lines of page 335 and as my learned friend commented this morning, that seems to be the ancestor of our section 15 of the 1969 Act and it's in very similar language, it contains the reference to arrangements as our section does and it says, "Nothing in this Act shall be construed as

preventing a patient who requires treatment for mental disorder from being admitted…" and so on. So, in my submission, that wording makes it clear that it's not an authority to provide treatment, it's simply clearing out of the way any previous prohibition and reviving, if you like, the common law position as it was before the prohibition existed. In England, that dates at least from 1890 and wasn't removed in England until 1930 so 20 years after that happened here. Certainly the English commentators on that section seem to have been more or less united in the opinion that the authority to treat informal patients in England is derived from the common law, not from the statute. That's certainly the effect of the decision in the *Bournewood* case, which Your Honours have, and it receives some support from the Dimond article itself in the passage that I cited in my written submissions and although the author there concludes that the application of the leave and immunity provisions there to informal patients remains in doubt, she seems clearly to be expressing the opinion that probably it doesn't apply. That opinion also appears in the conclusion to that article, which is at page 337, where under the heading "Conclusions", she says, "(2) Section 139…" that's the leave and immunity provision, "…gives certain protection in relation to any Act, performed in relation to an informal patient under the Act, 95 percent of all patients are informal and they probably do not, therefore have to seek the leave of the Court to proceed unless they are complaining about an action taken under the Act or statutory provisions" and it was clear from the earlier part of the article that what she meant by that was, if the action that was being complained about was one that was expressly authorised by the Act and there were some examples given in the earlier part of the article.

McGRATH J:

Section 15 however, of the 1969 Act in New Zealand, is a more elaborate provision, isn't it?

MR CHAPMAN:

Yes it is, yes that's right.

McGRATH J:

And it goes on to speak of the superintendent of the hospital may, in his discretion, treat any person as well as admit.

MR CHAPMAN:

Yes.

McGRATH J:

Now that more elaborate form, I suggest, is somewhat against you.

MR CHAPMAN:

Well, in my submission, it's important to see this and the section 39 of the earlier Act in the historical context because, and I don't want to go over the material that's in writing, but historically, before the first of the Lunacy Acts, there was nothing to prevent treatment but there was nothing in the statute that would have authorised it either. Then there was the prohibition that was enacted, I think, in 1866 and continued until 1911 and the 1911 Act, in my submission, can be seen clearly as simply a removal of the prohibition. Now, I accept that the 1969 Act is more elaborate, as Your Honour says, but it's, if it was, and I'm sorry to repeat what my friend has said, but if it was not intended as authority, it's difficult to see why the phrase "pursuant to any arrangements" is there. It could have simply been left out and the position would at least have been clearer. The reference to arrangements does, in my submission, seem to argue that –

McGRATH J:

I acknowledge that the "pursuant to any arrangements" is the point on which your argument settles and I fully appreciate the force of that, but it's, I'm just really, I suppose, drawing to your attention that this further concept of, apparently in its discretion the superintendent being able to treat as well as, and to admit is rather suggestive that there is a statutory power to do those things. Admittedly, subject to whatever "pursuant to any arrangements" means.

MR CHAPMAN:

Yes. Well if one takes the phrase "admit him to hospital for treatment" in (b), in my submission, the words "for treatment" do no more than describe the point of the admission. If they were out, if they were not there, there would be, they would have to be inferred. It may also be a reflection of the point that the focus of the legislation shifted between 1911 and 1969. The emphasis in the 1911 Act is on control –

McGRATH J:

Yes.

MR CHAPMAN:

– and I think that was the point that Her Honour the Chief Justice was making this morning. By 1969 the focus has shifted more towards treatment and that maybe the explanation of why that phrase is there.

McGRATH J:

Thank you.

MR CHAPMAN:

Can I just deal very briefly with the – some of the English writing and I want to do no more than refer to, apart from the Dimond article, there's the four pieces of writing in the green supplementary bundle under tabs 2, 3, 4, and 5. I don't want to take Your Honours through them but simply draw attention to the point that Professor Finelli in his article, it's under tab 2, and it's a commentary essentially on the *Bournewood* case, appears to accept the view that the authority to treat informal patients, at least in England, arises from the common law and not from the statute. That is echoed by Professor Dawson in his two articles, the first one in the Law Quarterly Review and the second, which is a New Zealand article from the New Zealand Law Review and finally, on this there's the article by Ando which also contains a comment on the *Runighian* case. Now, I wonder if I might spend a moment or two on that because the *Runighian* case was cited in the Court of Appeal,

Justice Hammond in his judgment didn't accept that it was correctly decided and it's true that it's a Crown Court decision and the report is very brief. In addition to that, there is one other English case in which the application of the English leave immunity provision has been considered in relation to an informal patient, and that is the *Lebrooy* case which is in the respondent's bundle and which I became aware of only after I had prepared my submissions, but it's, in fact – well, first of all, I'd better say that it seems to be an oral decision and it's against a plaintiff appearing in person. It's in the respondent's bundle at tab 12. If Your Honours turn over to page 5 of the judgment, paragraph 14 and the Court said in the case of *Pountney v Griffiths* the House of Lords held that subsection 1, that's of section 139, extends to any Act provided it's been carried out and purported pursuance of the Act and that it's scope is not limited to acts done or purported to be done in pursuance of functions specifically provided for in terms of the Act itself. I therefore reject the claimant's argument that section 139 only applies to those who have been detained under the Act and I agree with Mr Norman that the section was engaged within the nature of the matters complained about by this claimant, who was an informal patient.

I simply want to comment on that passage by saying that with respect to the learned Judge, paragraph 15 is a non sequitur from paragraph 14 and the point is put quite concisely in the Jones article to which my friend referred this morning. Now that's in volume 2 of the appellant's bundle under tab 44. The passage in which that is discussed is on page, it's quite a long passage, starting at the foot of page 7 of the article, Your Honours will see about halfway down page 7 there's a heading, "To whom the section 139 apply" and then there is a passage starting near the foot of that page, "The long established view was that the requirement for leave applies only to patients who are formally detained." The author refers to *Runighian* and then discusses the *Lebrooy* starting a few lines down at page 8 but points out that the Judge's reliance in that case on *Pountney v Griffiths* was mistaken because it was not authority for the proposition that section 139 applied to conduct in relation to informal patients and the issue about the application to

informal patients didn't arise in *Pountney v Griffiths*. I don't want to read the passage, I'm content for Your Honours to read it subsequently.

Unless there is anything else on which I can assist Your Honours, anything of I think I could otherwise say is probably doing no more than repeating the written material and I'm content to stop there.

ELIAS CJ:

Thank you Mr Chapman. I should say, we've been greatly assisted by your participation and thank you for accepting appointment in this matter.

MR CHAPMAN:

I'm grateful to Your Honour.

ELIAS CJ:

Yes Mr Solicitor.

SOLICITOR-GENERAL:

Thank you very much Your Honours. I have a one page synopsis of the submissions which I'm proposing to present to the Court. If the Court so permits, I'll make that available to Your Honours now.

ELIAS CJ:

Thank you.

SOLICITOR-GENERAL:

Your Honours, it has become apparent during the course of this morning's presentations that a key focus for the Court will be the impact of the filter provisions upon persons treated in psychiatric hospitals run by hospital boards after the 1st of April 1972 and where those persons were neither committed or special patients. In stating that as being the key focus for the Court, I do not in any way understate or underestimate the other issues which are before the Court but with respect, I think that that will be the key focus for the Court. Can I, right from the outset, explain what the Crown's position is in relation to that

issue and then explain how we get to it by referring back to the submissions that I was proposing to make.

The Crown's position is that as at the 1st of April 1972 the legal description "informal patients" applied to persons who were in Crown owned psychiatric hospitals and who were neither committed or special patients. Persons who were in psychiatric hospitals run by hospital boards after the 1st of April 1972 and who were neither committed or special patients were not as a matter of law informal patients. Those persons were admitted and treated in those psychiatric hospitals pursuant to section 18A(3) of the Mental Health Act 1969. Now, that explains the position that the Crown ultimately wishes to take the Court –

ELIAS CJ:

Section 18, sorry, section 18?

SOLICITOR-GENERAL:

Capital A, three, of the Mental Health Act 1969.

ELIAS CJ:

A, three.

SOLICITOR-GENERAL:

Now, can I just change –

ELIAS CJ:

Were they in under it, or were they not prevented from being in, by virtue of the provisions of the Mental Health Act?

SOLICITOR-GENERAL:

The Crown's submission Your Honour is that was the method by which they became admitted in to such hospitals.

ELIAS CJ:

I see.

McGRATH J:

Do you say that that was the provision, or is it the case that section 18A(3) really recognises that there is a discretion lying somewhere else in the Act? This is back to the Chief Justice's point, that you used the word under, treated under section 18A(3). What I'm asking you is whether you rely on section 18A(3) as the provision or whether it is simply recognising another provision somewhere else?

SOLICITOR-GENERAL:

I think it is the key provision for admission, care and treatment of such persons.

McGRATH J:

Okay.

ELIAS CJ:

That's as I understood you to be putting it.

TIPPING J:

If it weren't for that provision, you'd been in dead trouble. I'm perhaps putting it rather colourfully Mr Solicitor.

ELIAS CJ:

I'm sure he wouldn't have been dead –

SOLICITOR-GENERAL:

The challenges will be greater. I had really set out to do four things in my synopsis of the submissions which were being made available to the Court. For present purposes, it would be more helpful if I actually turned to the consequences of the appellants in the amicus argument and then turn to what the Crown says is Parliament's intentions, then focus on the precise word of

the filter provisions and then the specific provisions relating to informal patients and other persons under the Mental Health Act.

The first consequence which needs to be emphasised and which I'm sure has already been appreciated by the Court, is that if the appellants in the amicus' arguments are accepted, an unacceptable distinction is created between committed patients and persons who are informal patients in a Crown owned psychiatric hospitals and other persons who are not special or committed patients in psychiatric hospitals managed by health boards. That distinction can be emphasised by taking Porirua Hospital, a psychiatric hospital run by a hospital board. If we examined one ward in that hospital it is quite conceivable that in that ward we would find two patients adjacent to each other. One a committed patient and the other a patient who is neither a committed or a special patient but who has become part of the hospital community through the section 18A(3) process.

Now according to the theory that's been advanced by the appellant and the amicus, the committed patient would need to seek leave from the High Court and meet the threshold for leave if that person wished to complain about alleged wrong treatment. Yet the other person in the adjoining bed who might wish to complain about exactly the same alleged inappropriate treatment, would be able to commence their proceeding at any time without addressing the threshold requirements in the filtered provisions.

ELIAS CJ:

But that's subject to a narrow reading of section 124?

SOLICITOR-GENERAL:

And I definitely want to address –

ELIAS CJ:

Yes, you'll come to that?

SOLICITOR-GENERAL:

I really do want to –

ELIAS CJ:

Yes, thank you.

SOLICITOR-GENERAL:

– address that very firmly Your Honour. I'm sorry if I sound –

ELIAS CJ:

Not dead in the water on that one.

SOLICITOR-GENERAL:

Far from it. Now that distinction, which I have endeavoured to illustrate by way of that practical example, is not founded on any statutory or practical differences in the kind of treatment or care actually being given to those two hypothetical patients. Yet on the approach which has been advocated by my learned friends, the exposure of staff to the risks of legal action, hinges entirely upon the admission status of each individual patient that they are dealing with. Even though the staff members maybe dealing with committed and other patients simultaneously, the status of a particular patient may well be in constant flux since the day that they were admitted and the perceptions of patients, regardless of their status, maybe as impaired as those of other patients and such persons maybe just as inclined to make potentially unsubstantiated allegations and it was that point that the Court of Appeal emphasised in its judgment at paragraph 143. So that anomalous consequence, in the Crown's submission, just simply could not have been intended by Parliament.

The second anomalous consequence concerns perverse incentives. Had Parliament truly intended to remove the protection afforded to health professionals by the filter provisions in relation to informal patients in Crown owned psychiatric hospitals, or other patients who weren't special or committed patients in psychiatric hospitals run by hospital boards, then there

would have been a perverse incentive created for health professionals to admit patients as committed patients. Parliament clearly didn't want to create this perverse incentive, instead the whole thrust of legislative reforms in relation to patients admitted into psychiatric facilities over recent decades has been to reduce the number of committed patients and encourage admission through informal processes.

The third anomalous outcome, which has been already seized upon by members of the Court, is the different approach that applies depending on which hospital a person happens to be in. It is a plank in my friend's arguments that after the 1972 reforms most admissions into psychiatric hospitals were via the Hospitals Act 1957. However, as we note not all psychiatric hospitals were placed under the care and control of hospital boards. Lake Alice and Queen Mary being examples of the – being the two that were not. Thus a distinction gets drawn between those who were admitted as informal patients into Lake Alice or Queen Mary Hospital as opposed to those who were admitted into hospitals managed by hospital boards. So if a person happened to be admitted by the section 18A(3) route into Porirua Hospital their case, according to my friends, would be treated differently from an informal patient admitted into Lake Alice or Queen Mary Hospital and such a distinction is illogical and clearly could not have been intended by Parliament.

ELIAS CJ:

Was there any – there was no discussion in section 124 at the time of the enactment, in the legislative materials at the time of enactment of the 1969 Act?

SOLICITOR-GENERAL:

Not of the 1969 Act Your Honour –

ELIAS CJ:

No.

SOLICITOR-GENERAL:

– but I certainly can take you to the legislative history of the predecessor of section 124.

ELIAS CJ:

Yes, no I've seen that because it's referred to I the judgments too but –

SOLICITOR-GENERAL:

Yes. Nothing in 1969 –

ELIAS CJ:

They're just simply carried on, the section 124 provision.

SOLICITOR-GENERAL:

Yes. Now the fourth anomaly which I wish to emphasise, which is a consequence of the appellant's and amicus' position is that Parliament's true intentions are frustrated. Now I know I will be needing to spend some time on explaining what Parliament's true intentions are but the filter provisions were designed to filter all but the most serious instances of abusive conduct by health professionals and it was Parliament's intention that health professionals in the Courts shouldn't have to consider misconceived and ill considered claims. The protective nature of the filter provisions was noted by Lord Bingham in the *Seal* judgment which can be found in the appellant's bundle of authorities, volume 2, tab 32. I'm referring to paragraph 18 of his judgment where in commenting upon the English equivalent of section 124 His Lordship noted that the words of the statute, "No proceedings, civil or criminal shall be brought…" quoting from Lord Bingham, "...appeared to be clear in their effect and have always been thought to be so. They were introduced with the obvious effect of giving mental health professionals greater protection than they enjoyed before." Very self-evident.

Now the approach which the appellants and the amicus urge upon this Court frustrates Parliament's intentions and permits unmeritorious claims to clog up the court system. To date two of the approximate 280 cases being brought by

my friends have been heard and those cases are in the respondent's bundles of authority in volume 1 under tabs 10 and 11. Both cases resulted overwhelmingly in judgments for the respondent and in both cases significant cost orders were made in favour of the respondent under section 40 of the Legal Services Act. One case took 18 days and the other 11 days and in both instances, elderly retired health professionals had to give evidence and to defend their reputations in relation to what were described as particularly egregious allegations said to have occurred decades ago. Now health professionals are vulnerable to these sorts of futile claims being brought by former informal patients of Crown owned psychiatric hospitals. Persons who were admitted into psychiatric hospitals under the auspices of hospital boards who were neither special or committed patients as well as committed patients.

TIPPING J:

The reason why such claims are not barred by the Limitation Act is presumably, is it, in part because the people are alleging they didn't have the mental capacity to bring them so you've got a kind of circularity in the picture?

SOLICITOR-GENERAL:

Yes and it has certainly been the Crown's intention to try and break the circularity, as Your Honour has put it, by having the filter provision applied properly.

ELIAS CJ:

Why is it circular? It's not circular, it's a different means of chopping it off, if your argument is correct, but it's not circular, is it?

SOLICITOR-GENERAL:

Well it is in effect, Your Honour, because as Your Honour will appreciate there is a very marked reluctance to strike out before trial on a limitation ground because the response of the Courts traditionally is it involves a question of fact which is best dealt with at trial.

ELIAS CJ:

Well, yes, so it's not circular, it's –

TIPPING J:

That may not have been an entirely appropriate metaphor on my part, but I think Mr Solicitor, there is no other control for this sort of case other than the filter.

SOLICITOR-GENERAL:

Precisely.

TIPPING J:

Is probably a more accurate way of putting it.

SOLICITOR-GENERAL:

Without going to trial.

TIPPING J:

Yes, without going to trial.

ELIAS CJ:

Yes.

SOLICITOR-GENERAL:

So without applying the filter provisions properly, Parliament's clear intentions are frustrated. So those are the four anomalous consequences.

McGRATH J:

What's the purpose behind the six month period?

SOLICITOR-GENERAL:

There is no indication in any of the materials I have looked at which explains why six months was chosen. There is nothing in the Parliamentary debates

which explains the six month time limit and there is nothing in any other materials which I have been able to locate which explains why six months was chosen as opposed to say 12 months or another period.

ELIAS CJ:

Well it's probably because it's a relict, it's something that's left over from the earlier legislation in which the actions were, the actions taken under the Mental Health Act were ones of confinement and committal.

SOLICITOR-GENERAL:

Yes but I will come on to that point Your Honour so that there is no uncertainty as to exactly what was permitted under the 1911 Act.

ELIAS CJ:

Well I'd like you to do that, but there are anomalies abound, it seems to me, because these people are treated, on your argument, much less well by the legal system than those who are patients and who are mistreated in other ways but are not psychiatrically impaired.

SOLICITOR-GENERAL:

Yes. Can I just deal with that one point Your Honour, of course our focus is on the Mental Health legislation, the provisions of section 124 can be found in other health related statutes as well and are still extent, there is a provision in the Tuberculosis Act of 1948 which is identical –

ELIAS CJ:

Is there anything in whatever governs general patients in the Hospitals Act?

SOLICITOR-GENERAL:

Not in the Hospitals Act but certainly in the Health Act of 1956, exactly the same provisions could be found.

ELIAS CJ:

I think it might be useful for you to just tell us what Acts similar provisions are in.

SOLICITOR-GENERAL:

Yes, identical provisions, Your Honour.

ELIAS CJ:

Yes.

SOLICITOR-GENERAL:

The Tuberculosis Act of 1948, please excuse me if I can't give you the section, the – I'll possibly get the name wrong, the Drug and Alcohol Addiction Act of 1966, it was section 129 of the Health Act 1956 and then section 124 –

BLANCHARD J:

Sorry, you're going a bit fast.

SOLICITOR-GENERAL:

I'm sorry Your Honour.

ELIAS CJ:

Drug and Alcohol Addiction Act?

SOLICITOR-GENERAL:

1966, now I just might –

ELIAS CJ:

Are these all cases concerning compulsory status imposed on people?

SOLICITOR-GENERAL:

Apart from the Health Act of 1956 Your Honour, which was the legislative provision which underpinned all public health in New Zealand at that time which covered a whole variety of subjects, clean water, refuge, control of

animals, as well as venereal diseases and other public health issues but that was a particularly broad statute Your Honour.

ELIAS CJ:

There was compulsory reporting of venereal disease, things like that wasn't there?

SOLICITOR-GENERAL:

There was indeed, yes, but it also provided protections, for example, to health inspectors who might go and close a facility because of concerns about contamination that might be occurring in a facility and matters of that nature.

ELIAS CJ:

What provision of the Health Act was that?

SOLICITOR-GENERAL:

That was section 129 from memory, of the 1956 Health Act Your Honour.

McGRATH J:

Does the equivalent English provision have a limitation period fixed?

SOLICITOR-GENERAL:

It did, and – it definitely did Your Honour, I'm just trying to remember if it was six months or another period of time.

TIPPING J:

Of course, it's not six months absolute, there are certain circumstances where the period is extended.

SOLICITOR-GENERAL:

Yes, yes.

TIPPING J:

And the sort of circumstances you would expect.

SOLICITOR-GENERAL:

Yes.

ELIAS CJ:

The English provision, you said it did or something like that, is it not –

SOLICITOR-GENERAL:

I'm sorry Your Honour, I was slightly distracted.

ELIAS CJ:

Sorry, is the English provision not still in effect? You just said it did, or something to that effect.

SOLICITOR-GENERAL:

Yes I did and that's because I thought the 1959 English statute was repealed in 1983 or thereabouts but – is that right, 1983, thank you, I'm grateful. I'm sorry Your Honour, I'm told that there was no time limit in the 1959 English statute and the extensions of time in the New Zealand filter provision are to be found principally in subsection (4) and the proviso to subsection (4) Your Honour.

TIPPING J:

I suppose the philosophy, and it's very hard to speculate, but the philosophy behind this is that if people have a genuine grievance, they'll get on and make it promptly and it's to stop these sort of retrospective, long after the event sort of situations, but of course you can still get leave.

SOLICITOR-GENERAL:

Yes.

TIPPING J:

But there's also a period of time after getting leave that you have to bring your claim within, isn't there, which all indicates the idea that you really had to get on with it.

SOLICITOR-GENERAL:

Precisely, yes. Can I just go back then to the 1911 – unless you wanted to pursue that point further Your Honour, can I just go back now to Parliament's intentions when it enacted the filter provisions and I propose to deal with the legislative history and I think I can do so very quickly. As Your Honours know, section 131 of the 1911 Act permitted those against whom any proceedings were brought to apply for a stay on the grounds that there was no reasonable ground for alleging a want of good faith or reasonable care or on the basis that the pleadings were frivolous or vexatious. So the original provision in 1911 put the onus on the respondent or the defendant to make the application and to do so on the grounds that there was no reasonable basis for bringing the proceedings.

The next legislative development occurred in the United Kingdom in 1930 when we had section 16 of the 1930 UK Act which switched the onus and made it a precondition for a plaintiff to obtain leave before any proceedings could be commenced and placed the onus on the plaintiff to establish sufficient evidence of bad faith or negligence as a precondition.

Now the policy reasons for this significant change were spelt out in the House of Lords in the Commons debates and the point that I'd like to make at this juncture is to say that it related more than just simply to the admission and the committal process. It related to more than just simply protecting health professionals, and in particular doctors, who initiated committal proceedings and perhaps one of the best statements of the policy for this quite significant change can be found in the address in the Commons of Ms Lawrence whose address can be found in the respondent's volume 2 under tab 15. Your Honours, I think there is – this starts off with the report from the Lords

and then it moves on to the Commons and on the second page of the Commons report at page 1834 –

ELIAS CJ:

Sorry, I'm behind.

SOLICITOR-GENERAL:

I'm sorry, Your Honour, volume 2 of the respondent's bundle of authority, tab 15, and I've taken Your Honours to the second page of the Commons debate which is the second part of the debates at page 1834 of the Hansard debate and Ms Lawrence, in that paragraph which commences, "It will be remembered…" through to the end of her, to the reference to clause 19 on the other page, really quite succinctly explains the policy reasons. Now clearly it related to the signing of certificates but it was more than just that and that's found towards the foot of that paragraph where she makes very clear reference to the concern that she and her parliamentary colleagues had about the general liability of health professionals to unmeritorious claims being brought by persons who had been in psychiatric facilities.

ELIAS CJ:

Against the people who had certified them?

SOLICITOR-GENERAL:

Yes that's at the beginning but then she doesn't confine it to that later. She talks about people bearing a grudge against everyone, a mass of baseless actions against doctors. That contribution to the debate was mirrored by other members of both the Lords and the Commons who spoke in relation to this particular provision.

ELIAS CJ:

Four o'clock in the morning.

SOLICITOR-GENERAL:

I have just taken you to Ms Lawrence's debate because I thought it was very succinct and focused but as I say, you get the same flavour from referring to other contributions made in the debates.

The policy for this filter provision, which does afford a quite unique protection to health professionals, was reaffirmed in 1957 in the United Kingdom Commission of Inquiry into mental health and that can be found under tab 22 of the same volume and a particular paragraph 490 of the Commission's report where there is a very succinct recommendation about the continuation of the leave provision – filter provision and it's the words in brackets, "Which affords protection for legal proceedings for persons who take part in the certification…" and here are the words I emphasise –

ELIAS CJ:

Sorry, where are we?

SOLICITOR-GENERAL:

I'm sorry Your Honour.

ELIAS CJ:

I thought it was tab 27, no?

SOLICITOR-GENERAL:

No Your Honour, sorry, tab 22.

ELIAS CJ:

Sorry.

SOLICITOR-GENERAL:

It's paragraph 490 and it's the words in parentheses which I'm particularly emphasising and it's the second half of the words, the second cluster of words after, "Referring to certification or other procedures." So while certification was high on people's minds, other procedures –

ELIAS CJ:

But there were other procedures not of which were related to retention and confinement –

SOLICITOR-GENERAL:

And also care and treatment.

ELIAS CJ:

Well later.

SOLICITOR-GENERAL:

Well with respect –

ELIAS CJ:

Where are they in the 1911 Act?

SOLICITOR-GENERAL:

In relation to voluntary patients they're very clearly there.

ELIAS CJ:

Well you'll need to take me to that.

SOLICITOR-GENERAL:

That's right. Can I just deal with that right away then Your Honour. If you go to the 1911 Act, section 39, which is page 622 of the statute. Subsection (1) deals initially with, "The ability of the superintendent to admit and detain a voluntary boarder for care and treatment."

ELIAS CJ:

But it's the admission and detention that this is directed at.

SOLICITOR-GENERAL:

But for a specific purpose, namely care and treatment –

ELIAS CJ:

Yes for the purpose but it's authority to admit and detain.

SOLICITOR-GENERAL:

Yes. And then to care and treat.

ELIAS CJ:

Well, I wonder about that but I understand that that's the submission you're making.

McGRATH J:

So back in that text of the Royal Commission report, you say the other procedures were looking to the equivalent of –

SOLICITOR-GENERAL:

Care and treatment.

McGRATH J:

Yes?

SOLICITOR-GENERAL:

Yes.

BLANCHARD J:

Is there any clue on this question of breadth in section 124(4) of the 1969 Act and I suspect this is probably in the 1911 Act as well? In the words, "In the case of a continuance of injury or damage" which aren't particularly apt to cover a situation of a claim for falsely committing someone.

ELIAS CJ:

Which subsection?

SOLICITOR-GENERAL:

Subsection (4) Your Honour. Yes.

BLANCHARD J:

I mean I suppose somebody could be struggling at the time and get injured but it seems a little unlikely that the words were there to cover that situation.

TIPPING J:

The conjunction of injury and damage too rather militates against that more restricted view.

SOLICITOR-GENERAL:

The –

TIPPING J:

The use of the word injury in association with the word “damage” suggests something a bit more than wrongful detention. Perhaps?

SOLICITOR-GENERAL:

And I can return to this point because –

ELIAS CJ:

Well as the appellants accept, if in the confining there is an assault, that’s covered, so I’m not sure that it’s a total answer to say that the reference to injury or damage –

SOLICITOR-GENERAL:

It’s the continuance of the injury or damage though, Your Honour, which I think is the point that is being –

ELIAS CJ:

The continuance, yes.

SOLICITOR-GENERAL:

It's the continuance of it that –

TIPPING J:

It presupposes that you're continuing to be detained, which I suppose is theoretically possible, but doesn't seem to be particularly – that reading would mean that you had six months after you ceased to be detained.

BLANCHARD J:

I wouldn't have thought it was for that purpose really.

TIPPING J:

No.

BLANCHARD J:

I suppose it's theoretically possible. It could be that as you're being cast into the padded cell, you bump your head and suffer an injury and the effects of that continue. I just think it's a little unlikely though that the words were to cover that situation as distinct from more general injury or damage that you might suffer as a result of something that occurs during your confinement. Are there no cases that deal with breadth?

SOLICITOR-GENERAL:

Yes there are, and there are two points which I wish to make. First, breadth, as you have very succinctly described it, was one of the key issues in the Court of Appeal in this case and the very arguments which are being urged upon this Court now were also argued for in the Court of Appeal, and the Court of Appeal ruled against my friends on that point and they didn't seek leave to appeal that part of the Court of Appeal judgment. They could have done so, they deliberately chose not to do so and the issue which has been presented for determination today shouldn't, with the greatest of respect, be allowed to expand into a topic which has been the subject of a specific ruling.

ELIAS CJ:

What's the specific ruling, did you say?

SOLICITOR-GENERAL:

If one goes to the Court of Appeal judgment and look at paragraphs 33 and 34 and 77, it will be found that what the Court of Appeal ruled was that the filter provisions cover more than acts or omissions in the committal process or acts or omissions expressly authorised by the legislation. The Court of Appeal ruled that acts in pursuance or intended pursuance extend to all conduct reasonably incidental to the care and treatment and control of patients and to the running of a psychiatric hospital. So we have the Court of Appeal being asked to make a specific determination on that very point. The Court of Appeal does so, and my friends had the option to try and seek leave to appeal that point and chose not to do so. In the Court of Appeal, I think it's reasonable to say that this issue was, certainly if not the most dominant issue before the Court of Appeal, one of the most significant, certainly occupied a lot more time than the issue which is currently before this Court and of course, there was quite powerful authority in support of the respondent's position as it was argued in the Court of Appeal, namely a highly regarded judgment of the House of Lords in *Pountney v Griffiths* where a number of very eminent counsel had argued what acts in pursuance or intended pursuance, now the English language is slightly different but what those English equivalent words meant and we had then Mr Gordon Slynn arguing for a very wide meaning, Mr Louis Blom-Cooper not disagreeing in any way, and amicus, Mr Woolf, all in agreement on the very wide interpretation which should be applied, an argument which was accepted by both the Court of Appeal and in particular the judgment of Chief Justice Widgery and then later by the House of Lords itself. So the Court of Appeal in this case was seized of argument on this very point and considered it in considerable detail against the background of quite powerful authority and my friends, having had the opportunity to try and challenge that in this Court, did not seek leave to do so.

So the policy for the wide meaning that the Court of Appeal has given to the filter provision, and for the wide meaning which the House of Lords have given

to the equivalent provision in the United Kingdom and which the respondent has argued for in the Court of Appeal, is the determination by the legislature to ensure that persons tasked with the very challenging occupation of dealing with persons suffering from psychiatric disabilities should not be the subject of unnecessary and ill-conceived proceedings without the Court making a preliminary determination as to whether or not the statutory requirements for being able to bring such proceedings have been met.

Now, if I can just focus on the specific meaning of the legislation which is before you and if I start with the 1911 Act, I have brought the Court's attention to section 39 and in particular the words "care" and "treatment", which Her Honour the Chief Justice has noted and I, with the greatest of respect, say that those words need to be given a meaning. The provisions of the 1911 Act relating to voluntary boarders were changed in 1961 and the key change there was that voluntary boarders became voluntary inpatients. In 1969, we have a new regime for the admission and care and treatment of informal patients as they had then become known, admitted into psychiatric hospitals, but it is, as I say, and section 15 in particular provides the legislative regime for the care and treatment of such persons, and in particular section 15(1)(b).

As I said when I first got to my feet, it is the events that occurred from 1 April 1972 that require, with respect, the greatest degree of focus. The position that I urge this Court to accept is that from 1 April 1972, persons could still be treated and cared for in psychiatric hospitals managed by hospital boards, however persons in psychiatric hospitals managed by hospital boards were admitted into those hospitals by the mechanism set out in section 18A(3). Persons who were informal patients as defined in section 2 could still be admitted and managed in psychiatric hospitals run by the Crown, that's Lake Alice and Queen Mary, but persons who were not committed or special patients but who were treated in psychiatric hospitals run by hospital boards didn't get labelled legally informal patients, they were simply persons admitted into such institutions pursuant to section 18A(3).

McGRATH J:

Coming back to something I raised a moment ago, but section 18A(3) speaks of not limiting or affecting the – sorry, "shall not limit or affect the discretion of an area health board to admit any person", doesn't that really imply that the primary discretion lies elsewhere, presumably in the hospital board legislation itself by this time?

SOLICITOR-GENERAL:

Not in the hospital board legislation –

McGRATH J:

Well the Hospitals Act, sorry.

SOLICITOR-GENERAL:

Not in the Hospital Boards Act either, what it does is it permits the superintendent of a psychiatric hospital as defined in this Act to admit a person into the hospital for care and treatment, even though that person is not a committed or a special patient.

BLANCHARD J:

It's an extraordinarily oblique way of doing it.

SOLICITOR-GENERAL:

Long term, long term, it was of course intended that ultimately the mental health legislation would probably only focus upon committed and special patients but there was this intervening period when that hadn't occurred, and by 1992, the focus was solely upon committed and special patients.

McGRATH J:

Thank you.

TIPPING J:

But 18A is still within part 2 isn't it?

SOLICITOR-GENERAL:

It is.

TIPPING J:

Which doesn't apply prima facie to hospitals carried on by hospital boards.

SOLICITOR-GENERAL:

Correct.

TIPPING J:

So what they've done, in a rather, one would have to say, ham-fisted manner, is to, in effect, re-engage sections 14 and 15 and 18 but in a negative sense.

SOLICITOR-GENERAL:

Yes.

TIPPING J:

It's a very odd way of doing it.

SOLICITOR-GENERAL:

I'm not going to try and suggest anything else other than that one has to actually spend some time focusing upon this to really understand and make sense of it. I appreciate that it is not a straight forward –

TIPPING J:

Because literally, if nothing in part 2 applies, this doesn't apply either.

SOLICITOR-GENERAL:

But it does.

TIPPING J:

But it must.

BLANCHARD J:

It's extraordinary because they seem to have done it in the same section of the 1972 legislation. Subsection (1) put in a version of section 18A, subsection (2) put in a version of section 14.

SOLICITOR-GENERAL:

Yes.

TIPPING J:

Which ex hypothesi didn't apply to the subject matter they were dealing with.

SOLICITOR-GENERAL:

Yes but it must.

WILSON J:

Well, if the legislative intention in 1972 was to apply section 124 to informal patients and board hospitals, why not simply so that?

SOLICITOR-GENERAL:

It's the labelling, again, that's the problem because informal patients as you've described them, weren't in –

WILSON J:

I appreciate there's no legal status, I'm using it in an informal sense.

SOLICITOR-GENERAL:

They were literally any person who wasn't a committed or a special patient.

BLANCHARD J:

I suppose there may be some significance in the sequencing in the 1972 legislation. That they put section 18A in first and then you read section 14 subject to that.

SOLICITOR-GENERAL:

Yes, well that's certainly the way I've interpreted it.

BLANCHARD J:

So, you don't read them in the order that they appear in the legislation, in the main legislation.

SOLICITOR-GENERAL:

I'm sorry Sir, yes.

ELIAS CJ:

What, section 18 and section 14?

BLANCHARD J:

Yes.

SOLICITOR-GENERAL:

It's certainly the way I have interpreted it, involves me going to section 18A(3) first.

TIPPING J:

You've got to read this in a sequence that makes sense of the whole, haven't you really?

SOLICITOR-GENERAL:

Yes.

BLANCHARD J:

Well, that's how the drafted – that's the sequence in which the drafter seems to have drafted it, 18A first so that's subsection (1), 14 second as subsection (2) of, in each case, section 3 of the 1972 Act.

SOLICITOR-GENERAL:

There are other matters which I don't want to let slip by and that concerns firstly, the reason for this, quite frankly, clumsy piece of legislation. It related solely to the change in ownership of certain psychiatric hospitals. It didn't alter the medical status of the persons who were in those hospitals. It didn't alter the way they were managed or treated.

TIPPING J:

But it did alter this informal patient status because it took it away as a matter of law?

SOLICITOR-GENERAL:

It took away the legal description of informal patient from a certain group of patients.

TIPPING J:

Yes.

SOLICITOR-GENERAL:

Yes.

TIPPING J:

Why did they do that, is there anything to give a clue to that? What was so inimical, if you like, about this concept, this legal status, that they thought as part of this just reorganising the system they had to change it?

SOLICITOR-GENERAL:

I don't know the answer to that Sir. What I can say is that there were nevertheless a number of provisions in the Mental Health Act of 1969 which continued to apply both to informal patients as legally defined and other persons who were in psychiatric hospitals, managed by hospital boards and who weren't special or committed patients.

ELIAS CJ:

Who were?

SOLICITOR-GENERAL:

Who were not special or committed patients.

ELIAS CJ:

Who were not.

SOLICITOR-GENERAL:

I'm deliberately trying to avoid the label informal patients for such persons.

TIPPING J:

They were 18A patients?

SOLICITOR-GENERAL:

They were 18A patients and that was extremely important but there were also other provisions. If I could just perhaps run through the key ones. Firstly, hospital boards, psychiatric hospitals continued to be defined as psychiatric hospitals under the Mental Health Act and hospital boards were required to carry on psychiatric hospitals pursuant to section 7(3) of the Mental Health Act 1969 so the hospital boards still had to be carried – I'm sorry, hospital boards still had to carry on the management of psychiatric hospitals, all psychiatric hospitals that weren't Crown hospitals, under section 7(3) of the Mental Health Act 1969. Those who admitted, either as informal patients in to the Crown psychiatric hospitals or who weren't special/committed patients in hospital boards psychiatric hospitals, continued to receive the protections set out in the Mental Health Act 1969. Such patients benefited from the supervisory roles played by inspectors and official visitors and the director general under section 56 and section 121 of the Mental Health Act.

TIPPING J:

Sections 106?

SOLICITOR-GENERAL:

Sections 56 and 121 of the Mental Health Act. The protections afforded by the definition of specific crimes, if they were mentally disordered, set out in sections 109, 110, 112, 113 and 114. The statutory duty to keep registers and records, set out in section 51.

ELIAS CJ:

But they weren't specific, were they, those crimes to those in Crown institutions, were they?

SOLICITOR-GENERAL:

There were some that applied – I'm sorry, most applied to persons who were mentally disordered. An informal patient could be mentally disordered.

ELIAS CJ:

Yes.

SOLICITOR-GENERAL:

So could a person who wasn't a committed special patient in a psychiatric hospital run by a hospital board, still met the definition of being mentally disordered.

TIPPING J:

The point I take it you're making Mr Solicitor, is it didn't matter where they were, they still got the same level of protection.

SOLICITOR-GENERAL:

Precisely and that was protection that was afforded to them under the Mental Health Act of 1969. The provisions relating to the reception of visitors under section 61 and in some instances, the protections relating to the administration of estates of protected persons. The definition of protected patients also covered informal as well as the other patients.

ELIAS CJ:

Oh, did it?

SOLICITOR-GENERAL:

Yes, that's in 82(b) I think Your Honour. I'll just check that. Yes, it covered everyone other than special, oh no, it included special patients as well but it covered informal – the unnamed group and committed as well as special.

ELIAS CJ:

Sorry, that's section 82(b)?

SOLICITOR-GENERAL:

Eight two Your Honour, it's the definition of protected patient.

ELIAS CJ:

Oh, this is for the purposes of administration?

SOLICITOR-GENERAL:

Of their estates, yes.

ELIAS CJ:

Yes.

TIPPING J:

If, in the first period, the filter applies –

SOLICITOR-GENERAL:

Sorry, are we talking pre-1 April 1972 Sir?

TIPPING J:

Yes.

SOLICITOR-GENERAL:

Yes.

TIPPING J:

If in the first and that's very much a question of course for us – but if it applied during the first period up to that date, I have some difficulty understanding why the simple reorganisation of the system, whereby you transferred it from one ownership to another, was going to make the great big difference, that it didn't apply after that change because there doesn't seem logically to be any policy or other factor linked with quite a substantial change?

SOLICITOR-GENERAL:

Yes and that was the point that I was perhaps not making as clearly as I should have been, when I said that the whole driver for that 1 April 1972 change was simply one of ownership of the institutions. It had nothing to do with the care, the treatment, or the actual –

TIPPING J:

Yes. I'm sure you did make it clearly but I'm probably just thinking aloud. If only perhaps for the benefit of Ms Cooper in her reply.

McGRATH J:

Well I suppose Mr Chapman and Ms Cooper address this to the extent that they were saying that the policy was to treat those who were informal patients as just ordinary patients being admitted to the hospital and that they would come under whatever rubric of protection there might be under that legislation. They were moving from one regime to another and just a comment on that. I noticed that section 7(3) certainly transferring all contracts, debts and liabilities but it wasn't transferring immunities.

SOLICITOR-GENERAL:

Sorry Sir was that 69 was it? Of the 1969 Act, I'm sorry Sir, are you referring too?

McGRATH J:

Yes section 7 of the 1969 Act but it was I think enacted in 1972, wasn't it?

ELIAS CJ:

Came into effect in –

SOLICITOR-GENERAL:

No, no the Act came into effect in 1969 but these other provisions, these transitional provisions relating to the hospital boards came into effect on the 1st of April 1972.

McGRATH J:

Yes. I'm sorry there were two points there Mr Collins but one was I thought a general point that Mr Chapman emphasised in particular, that it was a move from one regime to another and in the regime the former informal patients were moving to, they were just to be treated as ordinary patients and therefore they weren't going to have anything that – his argument was that it was intended they wouldn't have the restriction of such provisions of section 124 because no other patients who were being dealt with by the hospital board would have them?

SOLICITOR-GENERAL:

My response to that Sir, is this. That yes, there was undoubtedly a policy drive towards de-stigmatising a lot of the concepts which related to the treatment of persons with mental disabilities but the whole purpose of the 1972 changes was to put the ownership of psychiatric hospitals not owned by the Crown, into hospital boards and to ensure that they were administered in the same way, not by central government, but by boards which administered non-psychiatric hospitals, but persons were still admitted into psychiatric hospitals if they had a psychiatric disability, a psychiatric hospital defined and established pursuant to the Mental Health Act of 1969 and the admission was through section 16A(3) of the Mental Health Act 1969 if they weren't a committed or a special patient – sorry, when I say 16 I meant 18.

McGRATH J:

18A(3).

SOLICITOR-GENERAL:

I meant 18A(3) sorry. And those provisions of the Mental Health Act that applied to persons other than committed – and there were many provisions of the 1969 Act that applied not just to committed and to special patients but also to informal patients in Crown –

McGRATH J:

Does it come down to this? That you think that what gives the light of Mr Chapman's argument is section 18A(3)?

SOLICITOR-GENERAL:

Yes.

McGRATH J:

Thank you. I think the other point I was making which perhaps this – was that section 7(3) in speaking of contracts, debts and liabilities of the Crown passing, they could have put immunities in there too, couldn't they, if they'd wanted to, but didn't?

SOLICITOR-GENERAL:

But didn't.

TIPPING J:

Well it's not really an immunity.

BLANCHARD J:

The more logical thing would have been to amend section 124, which appears as enacted in 1969, to have filter protection for the Crown, which would be effectively the employer, and for any person who's the actor.

SOLICITOR-GENERAL:

Yes.

BLANCHARD J:

You might have expected that if the hospital boards were to be protected they would have to be put in, inserted into those subsections.

SOLICITOR-GENERAL:

Can I just pause for a second, I think there is an answer to that. Oh, any, the words, yes of course, the words "any person."

BLANCHARD J:

Yes but –

ELIAS CJ:

But does an act.

BLANCHARD J:

Yes but it's the person who does an act. The employer is not perhaps doing an act. It might have to take responsibility vicariously for the act of the person who actually does the treatment negligently. But it's not an actor.

SOLICITOR-GENERAL:

Yes that's right. Well that point was also one of the five key points that the Court of Appeal decided and held that the Crown Health Funding Authority was entitled to the protection as afforded by section 124 when the sued – when the Crown are sued vicariously and again that point wasn't subject to any application for leave to –

ELIAS CJ:

It's very hard to separate these points though if we're construing the statute.

SOLICITOR-GENERAL:

Well I don't want to prolong matters at all Your Honour but there isn't –

BLANCHARD J:

I mean that argument might protect where the plaintiff was a committed patient. I don't know, it's very hard to make much sense of it.

SOLICITOR-GENERAL:

Well I had tried to steer a course through it which I – which suggests it does make –

ELIAS CJ:

Which could work.

SOLICITOR-GENERAL:

Which does make some form of sense.

ELIAS CJ:

I hesitate to raise the statute because I know you will say that it was raised and disposed of and hasn't been appealed but I am left with this real concern about the six month limit because it does constitute, on one view, discrimination against people who are mentally impaired and we, I mean we do have section 6 of the Bill of Rights Act to consider in interpreting legislation and it's not clear to me that immunity from wide tortious suit was really the purpose of this provision.

SOLICITOR-GENERAL:

Well there are two points I would make and the first is to go some way to agreeing with Your Honour that it is a fundamental cannon of statutory interpretation. That provisions which purport to restrict access to the Court should be interpreted as narrowly as is possible. So far as the Bill of Rights Act is concerned, even raising the issue, instantly triggers a number of responses. Not the least of which is a rhetorical question as to whether or not the sections 4, 5 and 6 regime of interpretation actually applies to events which pre-dated the Bill of Rights and that of course doesn't undermine the first point –

ELIAS CJ:

It's not to the events, it's to the legislation as it is to be construed today as the Interpretation Act requires.

SOLICITOR-GENERAL:

Legislation which ceased to exist in 1992, yes.

McGRATH J:

And the Bill of Rights of course, the Bill of Rights is a command to this Court to interpret legislation consistently with the Bill of Rights so it's an Act that's going on right now, here, never mind the historical nature of it. It's how we interpret the mental health legislation.

SOLICITOR-GENERAL:

I'm quite happy to try and engage in a *Hansen* type analysis if the Court wishes me to but –

ELIAS CJ:

No I'd rather you told us why this isn't, this interpretation is not discriminatory.

SOLICITOR-GENERAL:

What I can say and I hope I'm not –

ELIAS CJ:

As opposed to being a filter. I can entirely understand the filter mechanism. It's the six month limitation. Why is the Crown taking it? Why is the Crown taking the point, the limitation point? Which is probably the better question.

SOLICITOR-GENERAL:

And the reason why the Crown is taking the limitation point is because it does not believe, after investigating each of the cases that it's been able to investigate, that there is any merit in any of these cases.

ELIAS CJ:

Well let a High Court Judge determine that.

SOLICITOR-GENERAL:

We're happy for a High Court Judge to go ahead and exercise the statutory power that a High Court Judge has under section 124 to make that determination, quite happy for that to happen.

ELIAS CJ:

Without taking the six month point?

SOLICITOR-GENERAL:

If there is a legitimate claim, we will settle it, we're desperate to settle legitimate claims, we won't be clogging up the Court with unmeritorious defences.

ELIAS CJ:

I don't think anyone is suggesting that there shouldn't be – that Parliament didn't provide here a filter mechanism to winnow out the unmeritorious claims, it's the absolute bar that is entailed in the time limit that's the problem.

SOLICITOR-GENERAL:

Firstly, there's the exceptions in subsection (4) and the proviso to subsection (4).

ELIAS CJ:

Yes.

SOLICITOR-GENERAL:

So the clock doesn't necessarily stop clicking.

TIPPING J:

Without wishing to sound provocative, if it's a matter of interpretation, nothing can be done about the made within six months because nothing could be clearer.

SOLICITOR-GENERAL:

Precisely. But the Chief Justice raises, I think, an even more fundamental point and I want to make it abundantly clear, because I said so in the Court of Appeal, we examine each case and try very, very hard to see if there is any merit in any of the claims that have been made, and so far, of the cases that have gone to trial, it is quite clear that our assessment thus far has been entirely right. These cases have been brought in circumstances where, quite frankly, they shouldn't have been brought.

McGRATH J:

But that really is a bit collateral to our present task when we come to clarify the legislation and just, can I say that for my part, seeing you've raised *Hansen*, it's been on my mind for some time since I came to grips with this case to wonder, a justified limitation, how – I can see that section 124 would be a justified limitation other than in respect of the six months period, and if you – I want to invite you to say why a six months limitation period, with the proviso and so forth of subsection (4) of section 124, is a justified limit on the right of access to the Courts. I don't actually think it's a common law interpretation matter, I think it's a Bill of Rights section 6 matter.

SOLICITOR-GENERAL:

Well I start with the very first premise of *Hansen* of course, and that is, the Courts have got to look at the plain and ordinary meaning of the words and apply orthodox principles with statutory interpretation and the six month limit is there, clearly that was Parliament's intention, there can be simply no quibble or reason for suggesting that six months was not Parliament's very clear and unequivocal intention. So, applying a *Hansen* analysis, the Crown would say we don't – you don't need to even get beyond the first –

ELIAS CJ:

It was also Parliament's intention that a High Court Judge should determine this. What you seem to be saying is that the Crown will provide the filtering mechanism.

SOLICITOR-GENERAL:

No, no with the greatest of respect, I'm sorry if I've created that impression in Your Honour's mind.

ELIAS CJ:

I'm sorry.

SOLICITOR-GENERAL:

Far from it. We want these people to go to the High Court and make their applications before these things get off the ground, that's what we really want. But having been served with these proceedings in circumstances where we believe the application should –

ELIAS CJ:

I understand yes, the way the matter came before the Court.

SOLICITOR-GENERAL:

– have been made and it's just being ignored, we will investigate and if we can see any merit, we will endeavour to settle.

TIPPING J:

Could I just change the focus slightly to go back to the first point that was being debated a moment ago, why not add on the hospital board in the list of people in subsection (1). It may be that the answer is in subsection (2), in that, that says, "No proceedings, civil or criminal, shall be brought against the Crown or any person." Not any person who's done the act or any person in respect of any such act.

SOLICITOR-GENERAL:

Yes, I think that was the point that my friends were actually trying to make and I looked at (1) instead of (2).

BLANCHARD J:

It's quite interesting actually for them in 1969 to have contemplated criminal proceedings against the Crown.

SOLICITOR-GENERAL:

Yes.

ELIAS CJ:

Are you looking at subsection (6)?

TIPPING J:

Subsection (2). I think the drafting here shouldn't be regarded as having been weighed at a nice scale.

SOLICITOR-GENERAL:

Well, and if I may be permitted to make an observation, isn't that so true of so many of the statutory interpretation cases that get to this Court.

BLANCHARD J:

That's why they get here.

ELIAS CJ:

Sorry I interrupted and I think you were answering Justice McGrath.

McGRATH J:

Well you've said six months is six months and there's no other possible meaning, I think is the –

ELIAS CJ:

That was number one.

McGRATH J:

Yes, that was number one.

SOLICITOR-GENERAL:

Well that's the first step, of course, in the *Hansen* analysis, is to – for the Court to apply –

McGRATH J:

Just unjustified limits, just justified limitations, yes.

SOLICITOR-GENERAL:

Yes. And there's no textual basis or any other basis for reaching any other conclusion.

McGRATH J:

We have to apply section 6 to the whole of section 124 I suppose?

SOLICITOR-GENERAL:

Yes.

McGRATH J:

Not just to the words "six months."

TIPPING J:

I think the answer may be that it's an unjustified limit if you choose to take that view, but there's nothing that can be done about it because of section 4, and if the Crown wants to consider whether it should be made more generous, well of course, it's all gone now anyway.

McGRATH J:

I'm sorry, that was – the point I was making I think was that may be we have to come back to look at this intended pursuance, or other provisions of the Act. When I say looking at – if we've commanded to apply possible

interpretations that are rights consistent, we may have to look at areas where there may be ambiguity in other parts of section 124 are not contending this much ambiguity in the words “six months.”

SOLICITOR-GENERAL:

Thank you for that indication Sir.

ELIAS CJ:

Yes, exactly. Even I can read it like that.

SOLICITOR-GENERAL:

I’m very, very conscious of the time, I did have some other points to make but I think the two gravamen of the Crown’s case has been put. Can I just pause for one second to make sure there isn’t anything glaring that I’ve overlooked?

ELIAS CJ:

Yes.

SOLICITOR-GENERAL:

Thank you very much Your Honours.

ELIAS CJ:

Thank you Mr Solicitor. Now, Mr Chapman we wouldn't normally call on you in reply, was there anything urgent that you wanted to say to us?

MR CHAPMAN:

Well I was assuming that if there was going to be any reply it would come from my learned friend Ms Cooper.

ELIAS CJ:

Yes, that’s what I had envisaged but I’m simply inviting you, if there was anything that jumped out at you.

MR CHAPMAN:

Well if I can do so very briefly, and I mean briefly.

ELIAS CJ:

Yes.

MR CHAPMAN:

There are really only three things I want to say and my friend will no doubt want to add to them, but I want to just say a word about section 18A(3), seeing that's been the focus of attention and simply to reiterate, if I hadn't made it completely clear, and perhaps Justice McGrath has made the point for me, but it does seem, with all respect, that section 18A(3) must necessarily refer to a discretion or an authority, whatever it does refer to, that is found somewhere else. It can't, in its terms, in my submission, be an authority on its own. It clearly refers elsewhere and the difficulty is that the elsewhere is certainly nowhere to be found in this statute. If it's in the Hospitals Act or the common law, that doesn't, of course, assist the respondent. The second point I wanted to make was in relation to the two cases which my learned friend the Solicitor mentioned had been heard and he spoke of them as having been examples of situations where Parliament's intention had been frustrated, to which I want to respond –

ELIAS CJ:

I don't think you need to address us on that because we are looking at this as a matter of principle without considering the merits at all.

MR CHAPMAN:

I'm obliged Your Honour. Let me then just pass very rapidly to the final point I wanted to make, or perhaps final but one, now I think of it. The penultimate point is very brief and it simply picks up my learned friend's reference to section 129 of the Health Act which, as he said, contains the same provision as section 124, I think word for word and to simply draw attention to the decision I think of Justice Bisson in *Carll v Berry* which is in the casebook that Your Honours have, where in that case in a quite different context of course,

the Court held that the filter didn't apply because the acts that were the subject of the complaint were not acts which the health inspector in that case had any duty to perform in terms of the statute.

Finally, just one other observation which is, if in relation to informal patients the 1969 Act changed the position and Your Honour the Chief Justice was suggesting that it did, we're left in the curious situation where in the same enactment with foreknowledge of what was going to happen in 1972, Parliament would then be taken to have introduced a regime which was then going to cease to exist on my argument, two or three years later which seems a curious thing to do, to apply the filter to informal patients possibly for the first time only to have it disappear again in a couple of years from then which suggests, in my submission, that perhaps the change wrought in 1969 for the period prior to 1972 may not have been as great as might otherwise appear.

That's all I wish to say, thank you.

ELIAS CJ:

Yes, although it may also mean adversely to you that section 124 always did apply to informal patients –

MR CHAPMAN:

I accept that that's –

ELIAS CJ:

– which is really what the Solicitor-General was saying.

MR CHAPMAN:

Indeed, yes.

ELIAS CJ:

Thank you Mr Chapman. Yes, Ms Cooper.

MS COOPER:

I'll also endeavour – I will be brief. I think I'd just observe first that the Solicitor's argument in relation to the importance of section 18A(3) is certainly a different argument from that advanced in the written submissions. Essentially, if the appellant's argument is accepted, then there is a distinction between committed patients and informal patients and indeed, if one looks at the 1992 Act that's exactly the position now, that creates a different authoritative basis for treatment between informal patients and committed patients so that's, as I say, now that is exactly the position, there was a different regime, legal regime operating. So, don't think that that argument particularly assists the Crown.

Just wanted to, in terms of J and K, just wanted to note that they were both committed patients, so arguments in terms of informal patients, they are not cases that are direction on point and don't particularly help Your Honours in this case. Also, just wanted to refer you, in terms of the J case, to note that in fact Justice Gendall would have actually upheld the plaintiff's claim in that case but for the Limitation Act and I do want to note, Your Honour Justice Tipping noted that in a sense that the section 120 bar is the only bar. No, there is another very significant bar to these claims and that's the Limitation Act. In fact a number of these claims, J case for example, went through the High Court on the argument of whether the Limitation Act bar actually barred the proceeding going ahead and she was given leave under the Limitation Act, so that is another very significant bar on these proceedings that needs to be taken into account by the Court. Of course, for all of these plaintiffs, that is a very pertinent issue.

My learned friend has referred to the Health Act and *Carll v Berry*. I've actually addressed that specifically in paragraph 71 of my written submissions and noted the relevance of that case to the argument that we're making before the Court. Another point I just wanted to raise in that argument, if one compares that position with the Hospitals Act and again, that's addressed in my written submissions, section 86 of the Hospitals Act specifically provided for liability for negligence. I think that's a question that Your Honour raised, is

whether the Hospitals Act actually provided anything specific in terms of liability, yes, it did. That provided in section 86 for claims to be able to be brought in negligence if there had been negligent conduct, so it was quite distinctly different –

TIPPING J:
Was that with a filter, or with no filter?

MS COOPER:
No, no, there was no filter in the Hospitals Act.

ELIAS CJ:
And simply the ordinary Limitation Act?

MS COOPER:
Yes, yes. I just wanted to refer, my learned friend was drawing from the debates in terms of the Act because we had been making the point that the focus of the legislation was on certificates and procedures and my learned friend the Solicitor endeavoured to make some point about the reference to other procedures and I think there was a debate there as to whether that actually contemplated care and treatment. I suspect that in fact what the other procedures were, that the debate was about, were things like transfer of patients, discharge, escape those sort of technical provisions again, rather than actually the issue of care and treatment which of course our cases focus on.

There was quite a discussion I think in section 124 about the issue of continuing damage. It may assist Your Honours, this was a matter that was discussed by the Court of Appeal in the case that was heard at the same time as our case, *Longman,* and I suggest that Your Honours, if you want us to provide a copy of that case but that looked quite a lot at the issue of what continuing damage means and I think that will be of some assistance to Your Honours in terms of that interpretation.

TIPPING J:

It would be helpful I think.

ELIAS CJ:

Yes, we'd like to see that.

MS COOPER:

Yes, certainly, I'll provide a copy Your Honours. Just in terms of this argument that we're raising a collateral attack and that we could have appealed it. I just simply want to note Your Honours that that's exactly what the Crown did in fact. They actually hadn't been given leave to argue the scope of the immunity in the Court of Appeal and did so and so we actually hadn't addressed any of our submissions to the scope of the immunity when we actually came to argue the matter in the Court of Appeal. So, we were in a sense, taken on the hop and so our submissions essentially were not the very careful submissions that we had made in the lower Courts specifically dealing with the scope of the immunity in which we'd made quite considerable argument because that came in collaterally I suppose by the Crown arguing it. I just wanted to say that that was an issue that wasn't specifically, or we hadn't understood it to be part of the scope of the Court of Appeal's decision and so we hadn't specifically addressed argument as to that in our submissions.

ELIAS CJ:

You mean in the Court of Appeal?

MS COOPER:

In the Court of Appeal, that's right. So, we were in a sense asked to do it orally without actually having –

ELIAS CJ:

I don't understand the submission. Are you simply saying that because the Crown did it in the Court of Appeal you should be –

MS COOPER:

No, no what –

ELIAS CJ:

– allowed to do it here?

MS COOPER:

I don't actually accept that we're making a collateral attack on the scope of the immunity. It's always been the contention for the plaintiffs right from the beginning and one can see that from the decisions emanating right from the Associate Judge, that we have consistently argued that the immunity provisions do not apply to informal patients. That's actually been a consistent argument right throughout –

TIPPING J:

But that wasn't quite the point but I don't think we need dwell on this.

MS COOPER:

Yes, no. One issue that Your Honour Justice Tipping was raising is the question, why was informal patient status taken away. That is actually addressed at *Hansard*, it is in our cases and I think you could also get the references to in the bundle from the Crown's material where they are looking at the amendment to the 1969 Act but if you want to have a look at the debate of *Hansard* which is in our volume 2, tab 45, at page 1417 which is the last page, it's not clearly marked unfortunately but it is the last page of that tab. It is quite clear that the purpose of that change was because parliamentarians wanted the treatment of psychiatric patients to be on the same footing as general patients as much as that was possible and that's clear that that was the driving force behind the amendment to that legislation and that's consistent with the arguments that we've been putting.

TIPPING J:

So are you saying they're taking the opportunity of doing that in a Bill that was primarily focused on the structural change?

MS COOPER:

Well no because of course it was – well there were two parts to it because with informal patients of course, if you accept our argument, informal patients were being taken out of the context of the Act and being treated as general patients in hospitals run apart from the Crown, so by hospital boards, and that is completely consistent with Parliament's intention, that as far as possible patients who were being dealt with in psychiatric hospitals would be treated in the same way as those who were in general hospitals and I think that's the point that the Solicitor-General made in his text and it was the reference that I'd referred to.

I think that that's the point I think my – as Justice McGrath was picking up, that the policy was to treat those patients as ordinary patients so – which of course is the thing that continued in the 1992 Act. They just, as I've said, the fact –

TIPPING J:

But they won't get a change in nature. I mean, if they were perceived to have problems for mental health staff, that problem wasn't going to go away just because you were going to treat them in some other structure.

MS COOPER:

Well no I accept that Sir but the issue is really what the legal authority was for the treatment and whether you were going to treat informal patients as a special class of patients or whether you were going to treat them in the same way and subject to the same rights and limitations as general patients and the argument is, and that's clearly backed up by the *Hansard* debate, is that certainly when the 1972 – when the 1969 Act came in, is that it was in contemplation of informal patients being treated in the identical way to general hospital patients and that has been continued in the 1992 legislation where they simply don't feature at all.

TIPPING J:

I understand all that, yes.

MS COOPER:

But just in terms of – the final point I want to make is the reference to section 6 of the New Zealand Bill of Rights Act. I think the issue is, is that our client's are still subject to the 1969 Act and that's the effect of *McVeagh* and so certainly for our clients the issue of the interpretation of the 1969 Act is a very live issue and obviously effects their rights. I mean we wouldn't be here arguing – under the 1992 Act in fact there is no effective immunity so if our clients were covered by the 1992 Act we wouldn't have had to have sought leave at all but because they are subject to the 1969 Act because that's – and for a very limited number they're subject to the 1911 Act, that's much fewer, that's the reason we're here, having to have the debate.

McGRATH J:

So just, you mentioned *McVeagh*, what was that reference?

MS COOPER:

The *Attorney-General v McVeagh*.

McGRATH J:

The case, yes.

MS COOPER:

Yes. That was a decision of the full bench of the Court of Appeal and again it's a decision that I can provide Your Honours. That was an argument where Mr McVeagh's lawyers argued that because the 1992 Act had come into force at a time at which his case came to be heard, that the provisions of the 1992 Act should be given effect to rather than the 1969 Act and the Court there held that because his complaint was in relation to events that had taken place while the 1969 Act was in force, he was therefore still subject to the 1969 Act and it was directly relevant to the immunity provision and they found

therefore that he was subject to the immunity provision in the 1969 Act. So again if Your Honours would like that case –

McGRATH J:

I think we can access it. The case is –

MS COOPER:

Yes, that's very well known.

McGRATH J:

The case is well known.

MS COOPER:

It is. So unless there's anything further Your Honours, those are my submissions.

McGRATH J:

One matter Chief Justice – whether we have a loose end.

ELIAS CJ:

Yes we do. Yes.

McGRATH J:

Really Mr Chapman at one stage of course you were acting for Mr P and his appeal I think is at a stage where it's not being heard today. He has applied to have himself struck out. The Court hasn't made any order on that because we addressed the matter as you know at a conference in relation – which led to your appointment as amicus. But is it too simplistic to say that we should deal with Mr P's appeal ultimately in the same way we deal with Mr B's appeal or do we really just have to leave it in abeyance or strike it out or what?

MR CHAPMAN:

Well the alternative is for it to be formally available. The difficulty will be getting the requisite instructions to do that and I had rather thought that if that wasn't done the Court would simply dismiss it as not having been pursued, but subject to that I'm in the Court's hands.

McGRATH J:

I think that, unless Mr Solicitor-General wants to say anything about that, I think that's probably all we need to hear from you.

SOLICITOR-GENERAL:

Yes I would have thought procedurally the most appropriate course of action is for Mr P's appeal to be dismissed and everyone else's comes under the umbrella of the B appeal.

McGRATH J:

Thank you.

ELIAS CJ:

Thank you counsel for your help. We'll reserve our decision. It's a very difficult bit of legislation. Thank you.

COURT ADJOURNS: 4.06 PM