IN THE HIGH COURT OF NEW ZEALAND
AUCKLAND REGISTRY

CIV-2013-404-000351
[2013] NZHC 1702

UNDER	the Judicature Amendment Act 1972, New Zealand Bill of Rights Act 1990, Declaratory Judgments Act 1908, High Court Rules and the Common Law
IN THE MATTER	of actions for judicial review and declarations
BETWEEN	B First Applicant
	JENSINA ETHEL MAE STEELE Second Applicent
AND	WAITEMATA DISTRICT HEALTH BOARD Respondent

CIV-2012-404-005040

BETWEEN	C Applicant
AND	WAITEMATA DISTRICT HEALTH BOARD Respondent

Hearing: 20-21 May 2013

Counsel: RK Francois for Applicants
J Coates and P Le Cren for Respondent

Judgment: 8 July 2013

JUDGMENT OF ASHER J

This judgment was delivered by me on Monday, 8 July 2013 at 10.30 am pursuant to r 11.5 of the High Court Rules.

Registrar/Deputy Registrar

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Introduction

[1] In these proceedings, the applicants challenge the policy of the respondent to prohibit smoking in its hospitals and surrounding grounds. It is argued that the policy is illegal because it is inconsistent with the respondent's controlling legislation and the New Zealand Bill of Rights Act 1990.

[2] These are consolidated proceedings involving three applicants. Two of the applicants, Mr B and Ms C, have been psychiatric patients at North Shore Hospital in Auckland which is run by the respondent, Waitemata District Health Board (the WDHB). The other applicant, Jensina Ethel Mae Steele, is a former psychiatric nurse at Waitakere Hospital, also operated by the WDHB. By consent I have suppressed publication of the names of all patients including the applicants.

[3] The policy that is the object of the proceedings was not specifically defined in the pleadings, but was confirmed by Mr Francois for the applicants to be the

Waitemata District Health Board Smoke-free Environment Policy dated November 2009 (the Smoke-free Policy).

[4] The Smoke-free Policy records various introductory matters and that the WDHB is required to ensure that employees, patients and members of the public are protected from tobacco smoke in the workplace. It also states that the WDHB has a responsibility to encourage and support patients and staff not to smoke. All WDHB sites are smoke-free. No smoking is permitted inside WDHB buildings, vehicles or offices, and staff, patients and visitors may not smoke in external areas on any site owned by WDHB or controlled by them under a lease. They must leave the site if they wish to smoke. No tobacco products may be sold on WDHB premises, and staff may not purchase tobacco products on behalf of patients or supply tobacco products to patients. WDHB staff are to be proactive in offering to support staff and patients to quit smoking, and patients will be assessed. If they are smokers they are to be prescribed nicotine replacement products and referred to a smoking cessation service.

[5] Mr Francois was careful to emphasise that it is not suggested that there is any "right" to smoke. Further, the applicants accept that tobacco use is a significant public health problem in New Zealand. The WDHB's evidence that smoking is considered to be directly responsible for the death of around 5,000 New Zealanders per year was not disputed. Historically, around 400 deaths per year have been attributed to passive smoking.

[6] Rather than seeking to justify smoking, the applicants' focus was on illegality and breach of rights. It was a theme of Mr Francois' submissions that the smoking ban was cruel and unfair to smokers. Enforced abstinence causes suffering to smokers. He emphasised the fact that psychiatric patients who were compelled to be in a psychiatric ward from which they could not leave were effectively forced not to smoke.

[7] However, the applicants' claim is not just limited to psychiatric patients. Mr Francois explained that the claim was brought on behalf of other general patients

who were so bedridden that they were unable to leave the hospital buildings and grounds to smoke, and were thereby obliged to give up smoking while in hospital.

[8] Mr Coates for the WDHB, in response to these general assertions, did not accept that the Smoke-free Policy was cruel, or that it caused hardship to the extent claimed. He submitted that in the long term the Smoke-free Policy would advance the health of patients and protect non-smokers. It was accepted that the forced withdrawal from smoking for smokers was a result of enforced presence in a hospital ward. The WDHB considered that discomfort to the patient to be fully justified when measured against the long term benefits of abstinence to smokers, staff and other patients in the hospital, and the community generally.

[9] Causes of action alleged by the applicants seeking compensation, and the seventh and eighth causes of action of Ms C's claim which relate to different issues, have been adjourned by order of the Court. The remaining relief presently sought is of a declaratory or directory nature. A declaration is sought that the decision to impose the Smoke-free Policy is invalid and has no effect, as well as an order quashing or setting aside the Smoke-free Policy.

The applicants

[10] Mr B is 33 years of age. He suffers from diabetes and in 1998 was involved in a motor vehicle accident that resulted in a traumatic brain injury. He is diagnosed by the WDHB as having a psychotic disorder. He has been placed on occasions in the intensive care unit (ICU) of the WDHB, which he describes as a "locked, segregated, low stimulus unit". Patients who are in ICU are held under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHCAT Act) and are not able to leave. He has smoked cigarettes since he was 17, and smokes on average 15 cigarettes per day. He enjoys smoking cigarettes and deposes that they calm and relax him when he is stressed. When he is forced to stop smoking he gets irritable and at times angry, and feels "as though part of my freedom is taken away from me".

[11] Ms C has been diagnosed with bipolar affective disorder and held in the ICU run by the WDHB. She is a smoker. She states that smoking helps keep her in balance and calm her down. A lack of cigarettes makes her angry and irritable. She

states that she suffers intense nicotine withdrawal symptoms. She considers that smoking has a significant beneficial effect on her mental and physical wellbeing.

[12] Jensina Steele is a retired nurse. She was a psychiatric nurse for 40 years and was one of Mr B's nurses. She comments on having observed patients experience intense nicotine withdrawal symptoms in ICU, including varying degrees of irritability, agitation, anger and insomnia. These symptoms can be reported as part of a mood disorder that can be highly prejudicial to the patient. She believes that the blanket ban is wrong and irrational. She argues that the ban does not stop psychiatric patients from smoking, which they resume upon discharge. She comments on the difficulty that psychiatric patients have in challenging the Smoke-free Policy. She asserts the rights of a third party psychiatric patient in ICU, and comments on how the smoking ban has taken away a pleasure in his life and caused him nicotine withdrawal.

[13] She also describes the effect of the ban on her. She smokes around a packet of cigarettes per day, and when the smoke-free policy was introduced she found she could not smoke at night given her inability to leave the ward. She describes the intense cravings, irritability and agitation that this caused and steps she would take to get around it. She believes that the Smoke-free Policy discriminates against nurses and staff, as well as patients.

[14] I have also before me a great deal of evidence from both sides about what is happening overseas in relation to smoking bans, and the effectiveness of smoking bans on causing smokers to permanently stop smoking, and a commentary on the ethics of a smoking ban. I have not found it necessary to review that evidence in detail in this decision as, for reasons that I will set out, I do not consider that an analysis of the benefits or detriments resulting from the smoking ban or its ethics is required to determine this application.

Judicial review

[15] The applicants challenge the Smoke-free Policy on three traditional grounds of judicial review. The first ground is illegality, which on the pleading goes beyond an allegation of ultra vires, and extends to an alleged failure to preserve the activity

of smoking in dedicated rooms with ventilation, and a breach of the obligation to provide a safe working environment. Under that ground they also allege failure to take into account relevant considerations, including breaches of the code of patients' rights, a failure to uphold ethical standards, and a failure to take into account the United Nations Convention on the Rights of Persons with Disabilities. The second ground is irrationality. The third ground is a breach of natural justice, which includes an alleged failure by the WDHB to meet legitimate expectations.

[16] As is usually the case in judicial review, the grounds significantly overlap. The core issue is legality. Was the WDHB acting within the powers conferred upon it by common law and by Parliament in introducing the Smoke-free Policy?

The WDHB's powers and policy

[17] District Health Boards (DHBs) are statutory entities[1] and body corporates.[2] They may do anything that a natural person of full age and capacity can do.[3] The buildings in which the Smoke-free Policy is implemented are all owned and leased by the WDHB. Like any owner, the WDHB can set rules for their operation and set out requirements for the conduct of persons on that site. As Lord Bingham stated in *Kay v Lambeth London Borough Council*:[4]

> The public authority owner or landlord has, broadly speaking, a right to manage and control its property within bounds set by statute.

[18] Therefore a DHB, like any owner, can regulate the behavior and activity of patients, staff and visitors who use and access the sites it owns or leases, providing it does so consistently with its purposes, objectives and powers. It can prohibit entry of a person who may impede its operation or hurt its patients. It may impose conditions on those who enter its property to ensure that hospital activities are not adversely interrupted or affected. However, it may only do an act for the purpose of

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1 Crown Entities Act 2004, s 7.
2 Section 15(a).
3 Section 17. This section renders any consideration of the WDHB's "third source" power to do that which is not prohibited by law unnecessary: see *Ngan v R* [2007] NZSC 105, [2008] 2 NZLR 48 at [93]–[100].
4 *Kay v Lambeth London Borough Council* [2006] UKHL 10, [2006] 2 AC 465 at [36].

performing its functions.[5] It can only do things that fall within the objectives of DHBs as defined by Parliament in the New Zealand Public Health and Disability Act 2000 (the NZPHDA).

New Zealand Public Health and Disability Act 2000

[19] The purpose of the NZPHDA is to provide for the public funding and provision of personal health services, and amongst other things establish publicly owned health and disability organisations.[6] It is stated that this is in order to pursue various objectives. The first listed is to achieve for New Zealanders:

> (i) the improvement, promotion, and protection of their health:
>
> (ii) the promotion of the inclusion and participation in society and independence of people with disabilities:
>
> (iii) the best care or support for those in need of services:

[20] These objectives are to be pursued to the extent that they are reasonably achievable within the funding provided.[7] Under s 8(1), the Minister must determine a strategy for health services to provide the framework for the Government's overall direction of the health sector and improving the health of people in communities.

[21] DHBs are established under the NZPHDA.[8] A DHB is a Crown entity owned by the Crown, and the Crown Entities Act 2004 applies to each. Subsection 22(1)(a) states that every DHB has the objective, consistent with the purposes of the NZPHDA:

> (a) to improve, promote, and protect the health of people and communities:

[22] A further objective is to promote effective care or support for those in need of personal health services or disability support services.[9] Amongst the functions of DHBs set out in s 23(1) is the function:

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5 Crown Entities Act 2004, s 18.
6 New Zealand Public Health and Disability Act 2000, s 3(1).
7 Section 3(2).
8 Sections 5(3) and 19.
9 Section 22(1)(c).

> (h) to promote the reduction of adverse social and environmental effects on the health of people and communities:

It must foster community participation in health improvement[10] and be a good employer.[11]

[23] Mr Francois emphasised the reference in the introduction of the Smoke-free Policy to a purpose of the smoking ban being to comply with the Smoke-free Environments Act 1990 (the SFEA) and the Health and Safety in Employment Act. There was no mention of the NZPHDA. However, this paragraph is no more than a statement of compliance with those Acts, rather than a statement as to the power under which the Smoke-free Policy is implemented. The statement in the Smoke-free Policy that the WDHB is required to ensure that employees, patients and members of the public are protected from tobacco smoke in the workplace is consistent with the WDHB's powers. So too in my view is the crucial element in the Smoke-free Policy that all WDHB sites are smoke-free. Even if the "purpose" was incorrectly expressed in the words of the Smoke-free Policy which refers to the SFEA, the consideration of vires cannot be limited to that Act and must focus on the NZPHDA.

[24] It is necessary therefore to consider the ambit of the Smoke-free Policy and the limits of the WDHB's power. The NZPHDA does not specifically prescribe every action that may be carried out by the WDHB, and its powers must be construed broadly, consistent with the purposes of the Act. As McCarthy J stated in *Attorney-General ex relatione Lewis v Lower Hutt City*:[12]

> Further, in deciding what can fairly be regarded as incidental to express powers, the Courts do not think narrowly. They bear in mind the public nature of the functions of a local body and the requirements of its community, and they take a liberal view of the power under consideration.

[25] I note, however, the observation of the Supreme Court in *Cropp v Judicial Committee* where it was held that a wide approach to incidental and implied powers cannot be used where human rights are interfered with.[13] In such a case the test is

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10 Section 22(1)(h).
11 Section 22(1)(k).
12 *Attorney-General ex relatione Lewis v Lower Hutt City* [1964] NZLR 438 (CA).
13 *Cropp v Judicial Committee* [2008] NZSC 46, [2008] 3 NZLR 774 at [26]–[27].

necessary implication, consistent with s 6 of the New Zealand Bill of Rights Act 1990.

[26] As with any ordinary owner of a site that members of the public visit to obtain services such as a restaurant or a hotel, the WDHB has the right to impose conditions on those who enter its property so long as those restrictions are consistent with its objectives and functions. It may regulate the conduct of those who come on its site, insofar as those restrictions do not impose upon positive rights.

[27] Dr Patton, the WDHB psychiatrist and clinical director of mental health and addiction services, stated in his evidence that there have to be rules associated with getting care. In the hospital setting, it is not acceptable for someone to practice sexual promiscuity, or use alcohol or other substances or medications for their gratification. There is a clear risk posed by such activities for patients, either to themselves or to other people, even if those persons feel distress and that their autonomy is being restricted by not allowing that behaviour.

[28] Smoking is a recognised and preventable health hazard for New Zealanders. This is rightly not contested by the applicants. The containment and reduction of that hazard in my view falls entirely within the purposes of DHBs to "improve, promote and protect the health of New Zealanders". If a DHB bans smoking on its property as a matter of considered policy, it is taking steps to promote the cessation of individual New Zealanders smoking, and thereby protect their health and improve it, and protect others from tobacco smoke. The elimination of passive smoking promotes the same end.

[29] Given that smoking is a health hazard and that DHBs have a duty to promote policies to prevent or restrict health hazards, it is entirely within the powers vested in DHBs for them to have policies to stop smoking. Of course the power is not unlimited. The Act gives a DHB no power to dictate to New Zealanders how they should behave in their own homes or in places over which DHBs have no control even if they are DHB patients. It is to be noted that staff, patients and visitors are not prohibited by the Smoke-free Policy from smoking per se. They must leave the site if they wish to smoke.

[30] In relation to psychiatric patients and compulsory care, if there was no general smoking ban, enclosed areas away from where they are treated would have to be set up and monitored. Such places were provided and maintained before the ban. The applicants say there should still be such places. However, such special areas pose a significant extra cost. This is a factor that a DHB is entitled to take into account in allocating scarce resources. There is also the risk of other passers-by or patients for one reason or another gaining access to the smokers' area and suffering from the effects of inhaling their smoke. A DHB is entitled to determine whether it should provide a place where patients can carry out a process that is a health hazard to themselves and others.

[31] Further, the Health and Safety in Employment Act 1992 requires employers to provide and maintain a safe working environment for employees,[14] and to ensure that while at work employees are not exposed to hazards in or near their place of work.[15] A place of work includes a place or part of a place under the control of the employer,[16] and a hazard includes a situation where a person's behaviour may be an actual or potential cause or source of harm to the person or another person.[17] Under s 8, significant hazards to employees are to be eliminated if practicable.

[32] With the potential harm to employees posed by inhalation of the smoke of others, the Health and Safety in Employment Act can also can be seen as a justification of the Smoke-free Policy as it applies in hospital buildings, although less so in relation to external areas where employees are unlikely to go.

Smoke-free Environments Act 1990

[33] The applicants focused much of their submission on the issue of legality on the application of the SFEA to hospitals, and whether that Act allowed the respondent to impose a total prohibition on smoking. I do not see that Act as the critical Act that gives the WDHB the power to impose its policy. As I have set out, this power is given by the NZPHDA and the general rights of an owner to control the

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14 Health and Safety in Employment Act 1992, s 6(a).
15 Section 6(d).
16 Section 2.
17 Section 2.

activities of those on its property. I reach that conclusion despite the Smoke-free Policy under the heading of "Purpose" confirming "WDHB compliance with the Smoke-free Environments Act 1990 and amendments 2003 and the Health and Safety in Employment Act 1992 and amendments 2002".

[34] In *Progressive Meats Ltd v Ministry of Health*,[18] Baragwanath J considered that a purpose of the SFEA was the reduction of smoking. The Court of Appeal[19] did not express a view on this, deciding the matter on a different basis, but referring to the Act's "narrower purpose of ensuring non-smokers are not affected by smoking".[20] This seems to me, with respect, to be the concern of the SFEA and not the abolition of smoking.

[35] Mr Francois submitted that there is nothing in the SFEA that authorises the Smoke-free Policy. I accept that submission. That Act is stated to have four main purposes: to reduce non-smokers' exposure to detrimental health effects caused by others smoking; regulate and control the promotion of tobacco products; monitor and regulate the presence of harmful constituents in tobacco products; and establish a health sponsorship council. It does not have as one of its stated purposes the reduction of smoking by smokers.

[36] Under s 5 of the SFEA, smoking in work places is prohibited. Under s 2 of the Act, there is a distinction drawn between an internal area and an open area, and work places do not extend to open areas. That definition meant that in *Taylor v Manager of Auckland Prison*,[21] Gilbert J held that the SFEA did not restrict smoking in prison yards, relying on s 6A of the Act which related specifically to smoking in prison cells.[22] I accept Mr Francois' submission that the SFEA does not restrict smoking in open areas in hospitals, just as it did not restrict smoking in prison yards in *Taylor*.

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18 *Progressive Meats Ltd v Ministry of Health* [2006] ERNZ 892 (HC).
19 *Progressive Meats Ltd v Ministry of Health* [2008] NZCA 162, [2008] NZAR 633.
20 At [40] and [41].
21 *Taylor v Manager of Auckland Prison* [2012] NZHC 3591.
22 At [21].

[37] Gilbert J also held in *Taylor*:[23]

> Parliament would not have enacted s 6A requiring all prison managers to ensure that there is a written policy dealing with the effects of smoke from prisoners smoking in their cells if they did not anticipate that this would occur.

[38] However, there is no analogy between this case and *Taylor* in relation to the inside areas of the hospital or the further recent decision released since the hearing of this matter of *Taylor v Attorney-General* which focussed on specific regulation-making powers under the Corrections Act 2004 and s 6A of the SFEA.[24] Under s 6 of the SFEA, there is provision for a power for an employer to create dedicated smoking rooms in hospital care institutions, residential disability care institutions and rest homes. Unlike s 6A of the SFEA, the wording of s 6 does not anticipate that patients will smoke.

[39] Because s 6A assumed smoking to take place in prisons, Gilbert J held that Parliament did not intend for the rule-making power in the Corrections Act 2004 to extend to banning smoking entirely. In contrast, s 6 does not assume the existence of smoking in hospitals. The wording is clear: employers *may* permit smoking, *if* the statutory criteria are fulfilled. As a result, there is no conflict here between the exercise of power (the creation of the Smoke-free Policy banning smoking) and the anticipated operation of the SFEA. The analogy to prisons is further weakened by the explicit provision for prison cells to be excepted from the definition of "workplace". There was no similar or analogous exception for a room or rooms in a hospital.[25] The remarks of Brewer J in the second decision[26] of recognition of a right to smoke and the non-smoking policy being not humane was made in the context of the specific provisions that existed at the relevant time in the SFEA relating to prisoners. Thus, the decisions on smoking in prisons do not assist the applicants.

[40] I conclude that the WDHB was acting intra vires when it instituted the Smoke-free Policy. For the reasons I have set out, I conclude that the WDHB was lawfully exercising its powers as a Crown Entity under the Crown Entities Act 2004,

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23 At [22].
24 *Taylor v Attorney-General* [2013] NZHC 1659.
25 This exception was also repealed, along with s 6A, by the Corrections Amendment Act 2013.
26 *Taylor*, above n 24, at [30].

in a manner entirely consistent with its particular statutory framework under the NZPHDA. In instituting the ban on its grounds, inside and out, it was meeting its obligations under the SFEA, and was not acting illegally by electing not to provide for smoking rooms under s 6.

Relevant and irrelevant considerations

[41] From the materials that have been filed, the train of reasoning of the WDHB in implementing a smoke-free policy has been entirely straight forward. Tobacco smoke is a proven and accepted health hazard. The objective of improving patient and community health is best achieved by all property controlled by the WDHB being free of that hazard. There is no doubt that the paramount consideration behind the Smoke-free Policy has been the promotion of the health of patients and the community. This is a relevant consideration.

[42] It could be argued that the consideration of the practicalities of setting up smoking rooms, and the concern at the cost of creating these and supervising them, was an irrelevant consideration. However, a DHB must be able to take into account economic factors in promulgating policies. There can be no absolute rule. Sometimes to allow an economic consideration to dictate a critical outcome could be wrong. However, in this case I consider the economics of the alternatives are a relevant factor that could be taken into account by a DHB. I emphasise that this factor does not appear to have loomed large in the WDHB's considerations. Further, all the objectives of the Act are stated to be pursued "… to the extent that they are reasonably achievable within the funding provided".[27]

[43] Mr Francois claims that the WDHB failed to take into account three specific relevant considerations being:

(a) the rights of patients under the Code of Health and Disability Services Consumers Rights;

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[27] New Zealand Public Health and Disability Act 2000, ss 3(1) and (2).

(b) ethical principles set out in the Code of Ethics promulgated by the Royal Australian and New Zealand College of Psychiatrists; and

(c) the United Nation Convention on the Rights of Persons with Disabilities.

[44] These are not factors that are set out as of relevance in the legislation empowering DHBs. However, even if they were mandatory relevant considerations to be taken into account, the principle underpinning all three of these instruments, which is the promotion of the rights of patients, is consistent with the statutory objectives of DHBs to improve, promote and protect health. Those considerations have indeed been taken into account.

[45] I am satisfied that the WDHB did give careful consideration to the implications of its policy on patients who smoke. There were project groups and there was extensive consultation. Advice was obtained. It is possible to see the development of a policy incrementally over a 10 year period. I am satisfied that the WDHB took into account the impact of its policy on smokers.

Irrationality

[46] For the same reasons, I reject the argument of irrationality or *Wednesbury* unreasonableness. Even accepting that this Court will engage in more stringent review where the subject-matter of the decision-making engages individual liberties,[28] the Smoke-free Policy decided on was perfectly open to a reasonable body including health professionals, given the factors I have already mentioned in finding that the Smoke-free Policy is in line with the WDHB's statutory purposes.[29] It is not necessary to engage in an analysis of the differing medical opinions on the health benefits and detriments associated with a smoking ban. There is no doubt that there is a body of opinion that supports a smoking ban in the interests of patients, and it cannot be said that the decision was irrational.

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[28] *Manukau Urban Maori Authority Inc v Treaty of Waitangi Fisheries Commission* HC Auckland CP122/95, 28 November 2003 at [48].

[29] See [23]–[30] above.

Consultation

[47] The applicants argued that the WDHB had a duty to consult with "psychiatric patients and staff" before introducing the smoke-free policy. However, there was no such stated obligation to consult and nothing in relevant legislation that could be regarded as giving any party a right to be consulted on the issue. Given the constantly changing nature of patients and staff, there were limitations on who, apart from those mentioned below, could be meaningfully consulted. The express obligations on DHBs to consult in relation to their annual and regional plans where those plans are proposed to change do not apply.[30]

[48] In any event, there is evidence that there was consultation with staff and patients and others with an interest in the issue of smoking. There was no doubt that the issue of smoke-free zones is topical on a New Zealand-wide basis. Jocelyn Peach, a manager and Registered Nurse involved in the implementation of the Smoke-free Policy, details thoroughly in her evidence the scope of consultation engaged in by the WDHB throughout its 10 year development. The working group that was set up by the WDHB to manage the issue did consult with mental health stakeholders, including staff and consumer representatives. The statutory office of the District Inspector of Mental Health was involved. The affidavit evidence traces a lengthy history of interchanges between the working group and other organisations, and slow and cautious movement as the Smoke-free Policy developed.

[49] In particular, there was a pilot scheme for the Smoke-free Policy engaged in at the Mason Clinic, where there was a large patient population who were unable to leave the hospital premises. During that trial of the Smoke-free Policy, staff and patients were consulted on the effects and efficacy of the policy. The WDHB then accommodated the feedback received, including the development of sensory modulation rooms to modulate withdrawal symptoms of patients. The option of having smoking rooms was considered and rejected after this decade-long process of development of the Smoke-free Policy.

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[30] See New Zealand Public Health and Disability (Planning) Regulations 2011, regs 7 and 9.

[50] For these reasons, I conclude that even if consultation was required, the careful and extensive consultation efforts engaged in by the WDHB more than satisfied its public law duties.

Legitimate expectation

[51] Finally, there was a submission made of breach of a legitimate expectation. This seems to be put as a substantive legitimate expectation that the applicants could smoke somewhere in the hospital property. There is no procedural legitimate expectation pleaded. There were no facts put forward that could support such a procedural or substantive legitimate expectation by any person or group. It is not necessary to consider this issue further.

Breach of rights

[52] It is submitted that there had been a number of rights breached by the Smoke-free Policy. The primary focus was on the right to be free from discrimination, contained in s 19(1) of the New Zealand Bill of Rights 1990. The prohibited grounds of discrimination are set out in s 21 of the Human Rights Act 1993.

[53] The test for a breach of s 19 is to ask first, whether there has been a differential treatment or effects as between persons or groups in analogous or comparable situations on the basis of a prohibited ground of discrimination, and secondly, whether that treatment has a discriminatory impact.[31] To assess whether there is discrimination it is necessary to make a comparison between the claimant and someone in comparable circumstances to the claimant. There must be a difference in treatment between equal groups of persons, and that different treatment must be based on a prohibited ground of discrimination. It is helpful to identify a comparator group. A comparator is used as a tool, and cannot be seen as a formula for deriving an answer to the question of whether there has been discrimination.[32]

[54] To identify a comparator group it is necessary to:

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31 *Ministry of Health v Atkinson* [2012] NZCA 184 [2012], 3 NZLR 456 at [55].
32 At [60].

(a) identify a person or group whose treatment is logically relevant to the person or group alleging discrimination;[33] and

(b) a person or group that differs from the claimant in circumstances only on the basis of the alleged ground of discrimination, in other words a comparison of like with like.

[55] Two forms of unlawful discrimination were alleged in this case. First, between detained psychiatric patients and non-detained psychiatric patients; and secondly, between smokers, who it was contended suffer from a qualifying "disability" under the Human Rights Act 1993, and non-smokers.

Discrimination on the ground of psychiatric illness

[56] Mr B and Ms C argue that as ICU patients in the WDHB Mental Health Unit they are prevented from smoking, whereas non-ICU patients in the mental health ward are able to smoke by walking to the hospital's boundary. It is submitted that the comparator group is non-ICU patients in the Mental Health Unit, with the present ground of discrimination being psychiatric illness.[34]

[57] This claimed distinction is in fact not a distinction based on psychiatric illness. Persons with a psychiatric illness, if they are not ICU patients, are able to walk to the outside of the hospital grounds and smoke. Patients become ICU patients not because of their psychiatric illness, but because their behaviour is a danger to themselves or others. It is true that patients with these propensities are treated differently from other psychiatric patients because of the symptoms of their mental disability, which have resulted in their effective detention. But such symptoms are not a prohibited ground of discrimination.

[58] Another way of testing the appropriate comparator is to consider what happens to non-psychiatric patients. Certain patients who are not suffering from psychiatric illness and who are not in any way forcefully detained in the hospital are nevertheless also unable to smoke. This is because their illness or injury is such that

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[33] *Quilter v Attorney-General* [1998] 1 NZLR 523 at 573 (CA).
[34] Prohibited under s 21(1)(h)(iii).

they too are unable to walk to outside the hospital grounds because of the nature of their illness.

[59] As Mr Coates for the respondents pointed out, if the Smoke-free Policy in relation to mental health patients is regarded as discriminatory on the basis of the acuity of a psychiatric illness, then so will a whole range of other activities that the WDHB disallows. The question becomes: is it discriminatory for a hospital to stop a patient from doing something they would otherwise be able to do outside of hospital grounds?

[60] When patients are well enough to leave the WDHB premises, there is nothing to stop them accessing pornography, having promiscuous sexual relations and drinking alcohol. The answer to whether the WDHB is discriminating against ICU mental health patients or patients who are bedridden by preventing them from carrying out these activities in the unit must be "no". This is because it is not a form of direct discrimination to have a lawful policy that falls within the DHB's objectives that affects all patients, which may in a practical sense affect patients with certain symptoms and habits in a different way from others.[35] The basis of the prohibition is not because Mr B or Ms C are psychiatric patients of the hospital, or because Ms Steele is an employee; it is simply because they, like any visitors to the WDHB's premises, are on the hospital's grounds and must observe its rules insofar as those rules do not impinge on protected rights.

[61] I accept that Ms Steele could not smoke during the night shift that she worked when she was at the unit. But nor could she drink or listen to loud music. She was not being discriminated against because of an addiction. She was being treated like any other employee, patient or visitor. If she had been prohibited from smoking in the hospital's precincts due to a prohibited ground, that would be another matter; but the WDHB's lawful policy prohibiting smoking does not make distinctions on any such ground.

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[35] The argument that the Smoke-free Policy has a discriminatory effect as between smokers and non-smokers is considered at [64]–[69] below.

[62] This Policy can be compared to the discriminatory policy that was considered in *Ministry of Health v Atkinson*.[36] That policy there was to treat carers in a family relationship with a disabled person differently from other carers. The comparator group was all persons who were able and willing to provide disability support services. Here, in my view, the appropriate comparator group is those persons who are WDHB patients, visitors and staff.

[63] In this case, is there a differential treatment or effects as between persons or groups in comparable situations on the basis of a prohibited ground of discrimination? I do not consider that there is as all patients are treated alike, whether they have a psychiatric illness or not. All patients are prevented from smoking if they cannot leave the WDHB's premises. The reason that someone cannot smoke on WDHB grounds is not because someone is a patient or visitor, or because they are an employee, or any prohibited ground: it is simply because they are on hospital grounds. And the reason they are detained or unable to leave hospital grounds is not because they have a particular type of illness or condition; it is because for reasons of the symptoms they are displaying they have to be held, or are unable to leave.

Discrimination on the ground of disability

[64] The applicants emphasise that nicotine dependence and withdrawal are disorders recognised in the standard psychiatric diagnostic manual, the Diagnostic and Statistical Manual IV (DSM-IV). It is stated that the typical symptoms of irritability, anxiety, depression, panic attacks and severe cravings constitute a physical and/or mental psychological disability. In this submission, as I understand it, the alleged discriminatory focus is on the effects of the Smoke-free Policy on all smokers who cannot leave the site rather than just those with acute psychiatric illness, with the effects being different on smokers than non-smokers and therefore amounting to indirect discrimination.[37]

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[36] *Ministry of Health v Atkinson*, above n 31.
[37] Human Rights Act 1993, s 65.

[65] The term "disability" is defined in s 21(1)(h) of the Human Rights Act 1993. I am satisfied on the material provided that an addiction to nicotine is not a "disability". In terms of the definition, the evidence does not show an addiction to smoking or nicotine to be a physical or psychiatric illness, or an intellectual or psychological disability or impairment, or any loss or abnormality of a psychological or physiological structure or function.[38] It is a condition which can be overcome with varying degrees of difficulty and discomfort if the will is there, and the effects of forced abstinence do not have the gravity or permanence that I would associate with the "impairment" referred to in s 21(1)(h)(iv) or the "loss" or "abnormality" referred to in s 21(1)(h)(v). I have considered the views expressed by Drs Spriggs, Burns and Adams, and Ms Anderson for the applicants, and Drs Patton and McRobbie and Associate Professor Lawn, Ms Thompson and Ms Peach for the respondent. I have considered the evidence of the symptoms of nicotine withdrawal suffered by Mr B and Ms C while in WDHB properties. I accept the opinion of the WDHB experts that the symptoms were compounded by their illness at the time, and in Ms C's case her use of synthetic cannabis.

[66] It is my assessment that while the applicants suffered discomfort and some distress as a consequence of not being able to smoke, and that this will be a frequent experience of nicotine addicts subject to the Smoke-free Policy who are unable to get out of hospital grounds, that this does not amount to an illness or impairment as defined. Nicotine addiction is curable and does not disrupt a person's physical or psychological function to a sufficient degree to be accurately described under the Human Rights Act 1993 as a disability.

[67] The submission that a smoking ban is discrimination and nicotine addiction a disability has been considered in a number of Canadian cases, and rejected. It was stated in *McNeill v Ontario*:[39]

> … Smoking and the addiction that often accompanies it does not interfere with a person's effective physical, social and psychological function, the results that often characterise addiction to alcohol. Nicotine addiction and

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[38] There has been no suggestion of a breach of s 44 of the Human Rights Act 1993, and no discussion of ss 52, 53 or 56 of that Act.

[39] *McNeill v Ontario* (1998) 53 CRR (2d) 294 (ONCJ) at [32]. This decision was followed in *R v Ample Annie's Itty Bitty Roadhouse* [2001] OJ 5968 (ONCJ) at [64], and *Club Pro Adult Entertainment Inc v Ontario* (2006) 1 CRR (2d) 50 (ONSC) at [206]–[222].

> the symptoms of withdrawal that result when one discontinues smoking are not a mental or physical disability within the meaning of the s 15(1) of the Charter.

[68] The position is different from that say of a person in a wheelchair, bringing a claim because a building contains no wheelchair access. A person with a physical disability that constrains movement to a wheelchair can invoke a prohibited ground of discrimination. An addicted smoker who in my assessment does not suffer from a comparable level of illness or impairment cannot. To put it another way, it is legitimate for a policy to limit a particular activity, if that policy does not impact on a person with a disability as defined in the Human Rights Act 1993.

[69] It is not therefore necessary to consider the second question of whether the Smoke-free Policy has a discriminatory impact, and whether smokers suffered a "material" disadvantage.[40] I do record, however, that I do not accept the WDHB's submission that the Smoke-free Policy has an impact that is only trivial. While I accept that the respondent provides nicotine replacement therapy and other support, I consider that the evidence of Mr B and Ms C shows real and distressing symptoms that arose in part from them being nicotine addicts who were stopped from smoking. However, it is correct that there is no physical harm, and no permanent financial damage of the sort that arose in *Ministry of Health v Atkinson.*[41] While I accept that there was some physical and emotional distress being suffered by Mr B and Ms C as a consequence of them being unable to smoke when in the WDHB, the symptoms are not comparable in my view to those who suffer from a serious illness or psychological or physiological malfunction.

Right not to be subjected to torture or cruel treatment

[70] Section 9 of the New Zealand Bill of Rights Act 1990 prohibits torture and cruel, degrading or disproportionately severe treatment or punishment. In *Taunoa v Attorney-General*, Blanchard J defined the components of s 9 as follows: [42]

> [171] All forms of conduct proscribed by s 9 are of great seriousness. Without attempting exhaustive definitions, they can be understood in the

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40 See *Ministry of Health v Atkinson*, above n 31, at [110] and [136].

41 *Ministry of Health v Atkinson*, above n 31.

42 *Taunoa v Attorney-General* [2007] NZSC 70, [2008] 1 NZLR 429 at [171]–[172].

> New Zealand context in the following way. The worst is torture, which involves *the deliberate infliction of severe physical or mental suffering for a particular purpose, such as obtaining information. Treatment or punishment* that lacks such an ulterior purpose can be characterised as cruel *if the suffering that results is severe or is deliberately inflicted.* In the s 9 context, treatment or punishment is *degrading if it gravely humiliates and debases the person subjected to it,* whether or not that is its purpose.
>
> [172] The last of the matters listed in s 9 is treatment or punishment that is "disproportionately severe". This expression has no counterpart in the overseas instruments discussed above, but must take its colour from the rest of s 9 and therefore from the jurisprudence under those overseas instruments. I have concluded that *the words "disproportionately severe" must have been included to fulfil much the same role as "inhuman" treatment or punishment plays in art 7 of the ICCPR,* and to perform the same function as the gloss of "gross disproportionality" does for s 12 of the Canadian Charter. There might not otherwise be a classification in s 9 to catch behaviour which does not inflict suffering in a manner or degree which could be described as cruel, and cannot be said to be degrading in its effect, but which New Zealanders would nevertheless regard as so out of proportion to the particular circumstances as to cause shock and revulsion.
>
> (emphasis added.)

[71] The threshold is high and quite plainly not crossed by the applicants' case. There is no torture, as there is no deliberate infliction of mental or physical suffering. Nor is the ban imposed for a particular purpose such as obtaining information. Cruel treatment requires an element of the deliberate infliction of suffering, or which is particularly severe. The withdrawal symptoms resulting from the cessation of smoking tobacco do not, in my view, cross that threshold. I have referred to the consequences of nicotine addicts being unable to smoke.[43] There is no debasement or humiliation of the person, and the treatment is not so out of proportion as to cause shock or revulsion. In *Taunoa*, only one of the claimants was found to have suffered from severe treatment prohibited by s 9, and that was in the context of severe solitary confinement over long periods to a person with a psychiatric illness.[44]

[72] I do consider that the provision of nicotine replacement therapy by the WDHB, while not a panacea, is a humane and meaningful treatment of the symptoms of deprivation of nicotine to a smoker. That, and the other efforts that are

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43 See [64]–[68].

44 As held on appeal by the Court of Appeal, in findings undisturbed by the Supreme Court: *Attorney-General v Taunoa* [2006] 2 NZLR 457 (CA) at [212]–[226].

made to break the habit of smoking while not eradicating suffering, assuage any emotional or physical distress involved in the prohibiting of smoking.

Right to be treated with humanity and with respect for the inherent dignity of the person

[73] Section 23(5) provides that everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person. In *Taunoa* the Supreme Court described s 23(5) as protecting people "from conduct which lacks humanity, but falls short of being cruel; which demeans the person, but not to an extent which is degrading; or which is clearly excessive in the circumstances, but not grossly so."[45]

[74] In contrast to the harsh detention regime in *Taunoa*, a non-smoking policy is for the long term benefit of the patients, and conducted with humanity with nicotine replacement and other therapies being available to assuage the effects. In that case, Ronald Young J characterised the s 23(5) right as imposing a "positive duty" to ensure treatment "as befits a human being with compassion".[46] The cases in which s 23(5) has been successfully invoked have involved failures by authorities to provide basic human necessities such as sanitary products,[47] bedding and clothing,[48] or where there has been brutish and unnecessary use of police force.[49] I do not consider that refusal to provide smoking facilities is in the same category, even recognising the discomfort that nicotine deprivation does cause to addicts on WDHB property.

Right to respect private life

[75] The applicants rely on s 28 of the New Zealand Bill of Rights Act 1990 to claim a breach of the right to respect private life. They refer specifically to art 17 of the International Covenant on Civil and Political Rights which provides that:

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45 *Taunoa v Attorney-General*, above n 42, at [177].

46 *Taunoa v Attorney-General* (2004) 7 HRNZ 379 (HC) at [273] and [275], discussed in A Butler and P Butler *The New Zealand Bill of Rights Act 1990: A Commentary* (LexisNexis, Wellington, 2005) at 708–709.

47 *Attorney-General v Udompun* [2005] 3 NZLR 204 (CA).

48 *Taunoa v Attorney-General*, above n 46.

49 *Archbold v Attorney-General* [2003] NZAR 563 (HC).

> No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence …

Article 17 is broadly similar to art 8 of the European Convention on Human Rights.

[76] The short answer to this submission is that the Smoke-free Policy is neither arbitrary nor unlawful, as I have set out.[50] Further, in the context of a hospital environment, those who are in that environment have to accept limitations on their privacy and their ability to do what they want.

Right to natural justice

[77] Every person has the right to the observance of the principles of natural justice by a public authority that has the power to make a determination in respect of that person's rights or interests "protected or recognised by law".[51]

[78] For the reasons I have already set out, I do not consider that the applicants as smokers have any particular right protected or recognised by law. Courts have recognised the role of s 27(1) in contexts such as failures by judges to comply with requirements in the Mental Health (Compulsory Assessment and Treatment) Act 1992,[52] with the very serious ramifications such decisions have for individuals. Moreover, there has not been a "determination" as such in the decision to impose the Smoke-free Policy which is sufficient to invoke s 27(1). The determinations at issue must be "of an adjudicative character".[53] The application of a smoke-free policy does not have this character.

Section 5

[79] In case I am wrong, and the Smoke-free Policy does breach the applicants' rights, I go on to consider the position under s 5, which provides:

> **5 Justified limitations**

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50 See [15]–[40].
51 New Zealand Bill of Rights Act 1990, s 27(1).
52 *PS v North Shore Family Court* [2011] 2 NZLR 781 (HC).
53 *Chisholm v Auckland City Council* [2005] NZAR 661 (CA) at [32].

> Subject to section 4 of this Bill of Rights, the rights and freedoms contained in this Bill of Rights may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

[80] I approach this by adopting the approach set out in Tipping J in *R v Hansen*:[54]

> (a) does the limiting measure serve a purpose sufficiently important to justify curtailment of the right or freedom?
>
> (b) (i) is the limiting measure rationally connected with its purpose?
>
> (ii) does the limiting measure impair the right or freedom no more than is reasonably necessary for sufficient achievement of its purpose?
>
> (iii) is the limit in due proportion to the importance of the objective?

[81] Under s 5, the onus is placed on the policy-maker to demonstrate why the Smoke-free Policy is justified.[55] A Court must show restraint and caution when considering matters of policy. Courts must allow the decisionmaker some degree of discretion and judgment.[56] The Court must keep it in mind that its purpose is to reach a decision through structured reasoning rather than an impressionistic process.[57] I bear in mind that DHBs are specialist bodies, controlled by elected persons, many of whom are experienced health professionals. A policy such as this, which is the result of a discernible train of rational development and consideration, and which is clearly articulated, demands respect for that process and caution from a Court that is carrying out the s 5 evaluation. This approach does not, of course, extend so far as to abdicate any of this Court's constitutional role in guarding New Zealand citizens' fundamental rights.

[82] The limitation must be justifiable in the light of the objective. The objective here is to stop patients smoking for their own good and the good of other patients. In the light of the unchallenged evidence of the damage that smoking does to persons and our community, this is an important objective. I have no doubt this was a sufficiently important purpose to justify a curtailment of a right or freedom. It

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54 *Hansen v R* [2007] NZSC 7, [2007] 3 NZLR 1 at [104].

55 This analysis does not apply to the applicants' rights under s 9, given that the right to be free from torture is absolute: *Hansen v R*, above n 54, at [65].

56 *Hansen v R*, above n 54, at [117].

57 *Brooker v Police* [2007] NZSC 30, [2007] 3 NZLR 91 at [132].

follows also that a smoke-free policy is rationally connected with the purpose of improving health.

[83] The real question is whether the limiting measure impairs the right of freedom no more than is reasonably necessary for sufficient achievement of its purpose, and is proportionate. It was observed by Blanchard J in *Hansen*:[58]

> As will be seen, any limitation on a guaranteed right should be accepted as demonstrably justified only after the court has worked through a careful process. In the case of some rights, no limitation could be justified. The overarching rights not to be tortured or tried unfairly, for example, can have no meaningful existence as anything less than absolute protections. By contrast, within the contextually defined concept of fair trial sit some "subsidiary rights" such as that to counsel which, while expressed in unqualified language, may be legitimately qualified in their expression in particular circumstances without undermining the integrity of the criminal justice system. And no one would dispute that many of the freedoms enumerated in Part 2, for example freedom of expression, are in practice routinely limited to a greater or lesser extent by other concerns, both within and external to the Bill of Rights, which are demonstrably justified in a free and democratic society.

[84] There will be certain acts of discrimination where it will be most difficult to justify a limitation, and others where it will be much easier to do so. For reasons that I have already set out, I do not regard any disadvantage to the applicants as of a severe type that could be in any way equated to torture or other extreme suffering. Further, for reasons that I have already set out, the objective is not only a lawful objective but one which both sides accept as important and worthwhile: the reduction of the smoking. Patients will only be stopped from smoking while they are ICU patients or are so acutely unwell that they cannot leave by their own volition. As soon as they cease to have that status, they will be able to smoke outside the hospital grounds and when they are released from hospital they will be able to smoke in their homes. Nothing in the Smoke-free Policy interferes with these rights.

[85] Associate Professor Sharon Lawn in her affidavit details the benefits of successfully implemented smoke-free policies. In particular, she emphasises the need for a fundamental departure from the pervasive culture of smoking in mental health in order to stimulate real changes in behaviour. She says that any barrier to smoking, as well as a clear public health message to smokers, has a beneficial effect.

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[58] *Hansen v R*, above n 54, at [65].

She states that a period of abstinence has a direct health benefit for the patient, by changing patients' perceptions of their need to smoke. Further, Associate Professor Lawn details a number of studies that further demonstrate benefits of smoking bans for mental health patients, particularly where patients' quitting efforts were supported by assistance in the community.

[86] Dr Hayden McRobbie has also provided an affidavit describing the effects of smoke-free policies in psychiatric units. While suggesting that the evidence about such studies is "somewhat mixed", he states that patient populations in the medium to long term improve in terms of both their physical and mental health. He states that "a completely smoke free environment is crucial to promoting smoking cessation in mental health settings".

[87] Their opinions are not accepted by Drs Spriggs, Burns and Adams, or Ms Anderson, but I consider they have weight and provide justification for the Smoke-free Policy. I have considered the submissions of Mr Francois that, in the long term, the number of persons who are stopped from smoking, and who do not later resume, is small. While that may be so, and even if only a few give up permanently, that is in itself a significant achievement, and in the meantime they have had the health benefit of a period without smoke inhalation.

[88] The alternative of providing supervised smoking areas for patients would be expensive and hard to monitor. Equivalent resources would have to be provided to non-smoker patients. I note the assessment made by the majority of the English Court of Appeal in *R (N) v Secretary of State for Health* in considering the justification for a hospital smoking ban under art 8 of the European Convention on Human Rights: [59]

> … we agree with the conclusions of the Divisional Court that there is strong evidence of the dangers of smoking, both to smokers and to those subject to SHS and powerful evidence that in the interests of public health a complete ban was justified in appropriate circumstances. We further agree that substantial health benefits arose from the ban and, as experience has shown, that the dis-benefits were insubstantial. … In all these circumstances we agree that the Trust's policy would be justified under Art. 8(2) if Art. 8 were engaged at all.

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[59] *R (N) v Secretary of State for Health* [2009] EWCA Civ 795 at [72].

[89] Given what is, in my assessment, the relatively low level of disadvantage suffered by the applicants, and the significant advantages of enforcing a no-smoking policy, I conclude that the Smoke-free Policy is reasonably necessary for the achievement of its purpose. It follows that I consider that the Smoke-free Policy is proportionate to the importance of the objective of stopping WDHB patients, visitors and staff smoking.

[90] Thus, I conclude that if there was any limitation on the rights and freedoms of the New Zealand Bill of Rights Act 1990, it was of the type that could be demonstrably justified in a free and democratic society. I would uphold the Smoke-free Policy under s 5.

Summary of findings

[91] I conclude that the NZPHDA gives DHBs the power to implement a non-smoking policy, to protect patients, staff and visitors from smoke and to promote the cessation of smoking.

[92] This position is in contrast to the powers of those in charge of prisons that have been successfully challenged in this Court. They do not have the same functions and powers as DHBs, and were bound by s 6A of the SFEA, which anticipates that there will be smoking by prisoners.

[93] In deciding on the Smoke-free Policy there was no failure on the part of the WDHB to consider relevant considerations or the consideration of irrelevant matters. Nor was there irrationality, breach of duty to consult or breach of legitimate expectation.

[94] There was no discrimination on the ground of psychiatric illness in breach of the New Zealand Bill of Rights Act 1990. The restraint applied equally to all patients, staff and visitors and was not on the basis of psychiatric illness or acute illness. Rather, the Smoke-free Policy effectively prohibited smoking on the basis of particular features of the applicants' condition (danger to themselves or others or acuity of condition), or employment situation, that led to their detention or presence

on the premises, and consequent inability to leave the hospital property to smoke. There was no discrimination on the ground of a disability, as nicotine dependence from smoking is not a disability. There were no breaches of other human rights such as the right not to be subject to torture and cruel treatment.

[95] Even if there had been breaches of the applicants' rights, the Smoke-free Policy was a justified limitation under s 5 of that Act. The purpose of the policy was important, the ban was rationally connected with the purpose of reducing smoking and protecting persons from smoking, and the ban was proportionate and did no more than was necessary in its context to achieve its purpose of stopping smoking and protecting non-smokers from tobacco smoke.

Result

[96] The applicants do not succeed on any of their grounds of review, and the claims that were the subject of this hearing are dismissed.

Costs

[97] If there is an application for costs, submissions should be filed by the respondent's within 14 days and the applicants within a further 14 days, with a right of reply to the respondent in a further seven days.

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Asher J

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