Scottish Courts

SECOND DIVISION, INNER HOUSE, COURT OF SESSION

[2014] CSIH 71
P1265/12

Lord Justice Clerk
Lady Paton
Lord Brodie

OPINION OF LORD CARLOWAY, the LORD JUSTICE CLERK

in the reclaiming motion

CHARLES McCANN

Petitioner and Respondent;

against

THE STATE HOSPITALS BOARD FOR SCOTLAND

Respondents and Reclaimers:

Act: Leighton; Drummond Miller LLP
Alt: K Campbell QC; NHS Scotland Central Legal Office

12 August 2014

Introduction

[1] The issue that arises in this reclaiming motion (appeal) is the lawfulness of a decision by the respondents on 25 August 2011 to prohibit smoking and the possession of tobacco in the buildings and grounds of the State Hospital, Carstairs. On 27 August 2013, in proceedings for judicial review, the Lord Ordinary held ([2013] CSOH 143) that the respondents' decision was unlawful, although only insofar as it affected the petitioner, on the basis that it had not been taken in accordance with the principles set out in section 1 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act principles). He also held that it breached the petitioner's rights under Articles 8 (respect for private and family life) and 14 (prohibition of discrimination) of the European Convention on Human Rights. The petitioner was not awarded damages. The finding of the breach was regarded as "just satisfaction" (Article 41). This reclaiming motion challenges the Lord Ordinary's decision on the basis that the 2003 Act principles did not apply to the decision and that the petitioner's Article 8 rights were not engaged by the decision or, if they were, that the decision was a proportionate one.

The Statutory Framework

[2] Section 57A of the Criminal Procedure (Scotland) Act 1995 empowers a criminal court to make a "compulsion order" authorising the detention of certain persons in a specified hospital (see s 57A(8)(a)).

Section 59 authorises the court to "make a restriction order in respect of that person", whereby he becomes "subject to special restrictions set out in Part 10 [of the 2003 Act] without limit of time". The 2003 Act regime involves a regular review of the necessity for the orders by the patient's responsible medical officer. The responsible medical officer may recommend to the Scottish Ministers that the orders be revoked and that issue may in turn be referred to a Mental Health Tribunal. The patient himself may make an application to the Tribunal to revoke the orders. As long as they remain in force, however, the continued detention of the patient in hospital will remain duly authorised.

[3] The obligation to provide hospitals, which are required for persons subject to orders from the criminal courts, is contained in an amended version of section 102 of the National Health Service (Scotland) Act 1978 and rests upon the Scottish Ministers. The State Hospitals are "under the control and management" (s 102(3)) of the Ministers, although the Ministers can delegate the management to a Special Health Board. That is what was done by the State Hospitals Board for Scotland Order 1995, which provides that the newly constituted Board of that name (the respondents) "shall exercise the … functions" of the Ministers in relation to the State Hospital; specifically the function of management (para 4(1)(a)).

[4] The 2003 Act is an extremely detailed piece of legislation, which followed upon certain recommendations in the Millan Committee Report: *New Directions … on the Review of the Mental Health (Scotland) Act 1984* (SE/2001/56). As its title suggests, the Act is generally about the "Care and Treatment" of those in the mental health regime, including those subject to compulsion and restriction orders. The remit of the Committee was to review the operation of the 1984 Act, having particular regard to, amongst other things, "the definition of mental disorder; the criteria and procedures for detention in and discharge from hospital; leave of absence and care outwith hospital; …".

[5] The most significant principle emerging from the Report was that of the "least restrictive alternative" whereby "compulsion" ought to be "kept to a minimum" for the 10% or so of mental health patients for whom compulsion was necessary. The report reads (Introduction, para 4) as follows:

> "… any use of compulsion under mental health law represents a significant curtailment of the human rights of the patient, and should only be permitted when, and to the extent that, it is absolutely necessary. … our recommendations seek to ensure that any compulsory intervention is tailored to the particular needs and circumstances of the individual. This is a fundamental change from the current legislation where the powers granted on detention are always the same, regardless of the circumstances."

The proposals which then followed involved detailed alternatives to the existing criteria for compulsory measures, the creation of Mental Health Tribunals to deal with mental health issues and the introduction of a system of appeals against such measures. The Committee expressly considered (chapter 33) the European Convention, but primarily in the context of Article 5 (right to liberty), although there was also express mention of the control of correspondence (Article 8).

[6] The 2003 Act commences with an introductory part whereby the Act is to apply (s 1(1)) to a person "discharging a function by virtue of this Act". There is no statement of what functions are actually covered by the Act but, critically for the arguments in this petition, the person discharging a function must (s 1(2)) have regard to a number of factors, not least the views of the patient and all those involved in his care. He must (s 1(4)) thereafter discharge the function "in the manner that … involves the minimum restriction on the freedom of the patient that is necessary in the circumstances". The Act proceeds to deal in detail with compulsory measures of treatment in one form or another and the review of such orders. There are specific provisions in relation to compulsion and restriction orders.

[7] Section 286 of the 2003 Act, whose heading is "Safety and security in hospitals", permits the making of regulations by the Scottish Ministers authorising restrictions on "the kinds of things" which detained persons may have with them. The Mental Health (Safety and Security) (Scotland) Regulations 2005 authorise measures, including the searching of patients and the taking of swabs from them. They also permit measures relating to the search and surveillance of visitors. The authorisations appear to relate to measures which otherwise would, or at least could, be regarded as unlawful. However, for present purposes it is of some note to observe that regulation 4(c) does authorise restricting the "kinds of things" which patients may have with them (reg 5) when failure to do so would pose a significant risk to the health, safety or welfare of any person in the hospital or the security or good order of the hospital. The respondents have prohibited tobacco in the hospital but there is no suggestion that, in doing so, these regulations were invoked.

Government Policy

[8] *Smoke-free Scotland: Guidance on smoking policies for the NHS, local authorities and care service providers* (Scottish Executive and Convention of Scottish Local Authorities, December 2005) recorded the commencement of the legislation (Smoking, Health and Social Care (Scotland) Act 2005 and the Prohibition of Smoking in Certain Premises (Regulations) 2006) to remove second-hand smoke from most public places and workplaces and mentioned the health benefits sought to be gained as a result. It continued, in the Executive Summary:

> "Those working in the NHS, local authorities and other care service providers are invited, where possible, to go further than the legislation, working towards comprehensive smoke-free policies with the provision of cessation advice and support to those who wish to quit smoking".

It emphasised that there was no requirement to provide outdoor smoking. Specifically in relation to working outdoors, the Guidance asked employers to consider whether there ought to be different rules for those working indoors and outdoors. It suggested that good practice required a comprehensive, equitable approach. Section 4 was headed "Going Forward – The case for completely smoke-free" and advised that "wherever possible, consideration should be given to going beyond the legal requirements and moving towards the goal of being completely smoke-free". This section was not just about second-hand smoke but the benefits of stopping people (albeit particularly employees) smoking and of becoming a "smoke-free organisation". There is a particular section which dealt with "in patients" where it is said that "Patients being admitted for elective procedures should be advised that the hospital operates a smoke-free policy…".

[9] Some years later, the NHS produced: "*Smoke-free mental health services in Scotland: Implementation Guidance (2011)*". This was produced in the context of the legislation (2006 Regulations, Sch 1, para 16; Sch 2, para 4) which permitted designated smoking rooms in mental health facilities. It stated, in a foreword by the Minister for Public Health and Sport:

> "This … Implementation Guidance is a further step in the journey towards a smoke-free Scotland. Allowing smoking in designated rooms in residential mental health services, when it is completely banned in all other NHS settings, perpetuates inequalities...".

It referred back to an earlier statement by the Public Health Minister in 2010, following a public consultation, that guidance would be produced to help mental health service providers move towards "banning smoking altogether". It did note that, at that time, smokers retained a choice to smoke in hospital grounds. It also stated "Facts about smoking and mental health" to the effect that smoking has an adverse effect on mental health, especially schizophrenia. It distinguished between partial smoke-free and comprehensive smoke-free policies and referred to guidance from England that referred to smoke-free buildings and grounds as the

"gold standard" policy and gave reasons why hospitals should aim for this. It is worthwhile setting these out:

> "Communicates a strong message about the dangers of smoking
>
> Creates a smoke-free environment for people trying to stop smoking and removes triggers that cause many to smoke or relapse into smoking
>
> Avoids problems of deciding where smokers can smoke outside
>
> Avoids problem of smokers congregating at entrances to buildings
>
> Avoids problem of smoke drifting into buildings through entrances and windows
>
> Resources deployed on smoking shelters and cleaning litter could be better spent ensuring treatment is readily available
>
> When smoking is allowed anywhere on the premises the risk of fire breaking out remains."

Specific difficulties in relation to partial smoke-free policies were also mentioned, including negotiations over times when smoking is permitted. The Guidance stated that:

> "The prevalent message from previous international experience is that comprehensive smoke-free policies are more effective than partial policies in terms of adherence to the policy and present mental health hospitals with fewer problems overall."

[10] The most recent Government policy document, albeit published after the decision under consideration, is "*Creating a tobacco-free generation*" (March 2013). The foreword refers to the Government's aspiration for a "smoke-free Scotland", although it qualifies that by stating that this does not mean prohibiting tobacco or stigmatising smokers. It states that NHS Boards should be exemplars in providing smoke-free environments and goes on to refer to the provision of smoke-free grounds (but with an exception in relation to mental health facilities). Under a section dealing with second-hand smoke, it states that, notwithstanding the current allowance of smoking in certain parts of a prison, "creating a smoke-free prison service should be seen as a key step on our journey to creating a smoke-free Scotland". However, the context is specifically indoor facilities, as is the subsequent passage on mental health facilities.

Factual Background

[11] In or about 1995 the petitioner was made the subject of a mental health disposal. Somewhat alarmingly, neither party was able to inform the court just what that disposal had been, why it had been made or who (other than that it had been a sheriff) had made it. The precise terms of the warrant to detain the petitioner are therefore unknown. That is unfortunate in a case where the extent of the petitioner's freedom is, at least in certain respects, at issue. It is known that the petitioner was prosecuted at summary level for public disorder offences (see Lord Ordinary's Opinion at para [8]). It is averred and admitted that he is the subject of compulsion and restriction orders, presumably under the equivalent of the provisions in what is now the 1995 Act (ss 57A and 59). This has resulted in the petitioner being subject to the mental health regime and thus liable to be detained in hospital "without limit of time" (1984 Act, s 62 and 2003 Act Part 10).

[12] The petitioner has recently been transferred to the medium secure unit at Rowanbank. This reignited his desire to smoke. He was, for a time, able to indulge that habit again. However, because of his insistence on the damages claim, the petition is not rendered academic. Both parties were also anxious that the court resolve the matters of principle. The court was told that there is now a comprehensive ban on smoking at Rowanbank.

[13] Following the coming into force of the anti smoking legislation in the 2005 Act and the 2006 Regulations, smoking was prohibited inside psychiatric hospitals, including the State Hospital, except in designated smoking rooms (2006 Regulations, Sch 1, para 16; Sch 2, para 4). There was, and is, no legislative imperative to prohibit smoking outdoors, since that activity does not take place in enclosed premises, which alone can be designated, for criminal law purposes, as "no-smoking" (2005 Act, s 4(4)).

[14] In the context of a planned move into new buildings on the existing site in 2011, the respondents expressed a desire to introduce a comprehensive prohibition of smoking throughout the State Hospital. The design of the new buildings did not include any designated smoking rooms. At a meeting on 28 October 2010, having considered a detailed report from their medical director on the health and other effects of smoking and stopping smoking, the respondents considered whether a partial or a comprehensive smoking ban should be implemented in the absence of such rooms. A partial ban would have allowed smoking within the hospital grounds only. The respondents decided that they should "work towards" a comprehensive ban with effect from May 2011. By February 2011, however, the court had issued its decision in *L* v *State Hospital* 2011 SLT 233, and the respondents considered that they should, in light of that decision, revert to the *status quo ab ante*, which allowed smoking in the existing designated rooms although not in the new buildings, and consult on their aspiration to create an entirely smoke-free environment.

[15] A consultation with patients, staff and carers took place between 1 March and 31 May 2011. In June 2011, following the recommendations of a report from their chief executive on the consultation, the respondents resolved to implement a partial smoke-free policy, which allowed smoking in designated outdoor areas, subject to further consideration of the practicalities of implementation and any adverse "feedback". On 5 July 2011, "after careful consideration of the operational considerations and as no adverse feedback had been received", the respondents adopted the partial smoke-free policy, subject to review in November 2011. "Operational considerations" had included the practicalities of dealing with patients who smoked but did not have access to the grounds.

[16] From 1 August 2011, the respondents' intention had been that the designated smoking rooms in the existing buildings would be closed in preparation for the move to the new buildings on 21 September 2011. In the grounds, smoking was to be permitted only in designated areas, in which patients could be monitored by CCTV. Smoking was to be prohibited in ward gardens. Initially, it had been envisaged that patients who smoked, but had no access to the grounds, would be able to smoke under escort where this could be facilitated on an individual basis. Consequently, however, the respondents experienced increased numbers of higher risk patients seeking grounds access. It was eventually determined that these patients would be permitted to smoke in the gardens unescorted at agreed intervals throughout the day.

[17] In August 2011, the respondents had conducted a feedback exercise seeking the views of patients on "post smoke room closure". The survey revealed a grievance amongst non-smokers that the ward gardens had effectively become smoking rooms and amongst smokers that some wards gave fewer or shorter smoke breaks than others. There were also complaints about disruption to ward routines in order to accommodate smoke breaks. On 25 August 2011, following consideration of the results of the feedback exercise, the respondents determined that a partial smoking ban was "unworkable". This had followed a discussion on the effects of the partial ban on safety and security, operational and clinical disruption, time demands on staff and fairness and consistency. The respondents decided once more that the State Hospital would become a fully non-smoking environment; this time from 1 December 2011.

[18] From 21 September 2011, a revised version of the partial smoking ban was implemented, by which patients with grounds access, such as the petitioner, were permitted to smoke in the designated areas at all times during daylight hours. Patients without grounds access were permitted to smoke during daylight in the

"hub gardens" of the new buildings, under observation, at intervals, subject to clinical assessment of individual access arrangements at other times. The revised scheme of defined intervals was intended to remove inconsistencies and perceived unfairness in the operation of access arrangements by different wards. Finally, newly admitted patients were to be assessed individually for smoking cessation support and access to smoking facilities. These arrangements subsisted until the comprehensive smoking ban eventually took effect on 5 December 2011.

[19] Meantime, there had been a resistance movement amongst the smokers. At the beginning of 2011, the Patient Advocacy Service had co-ordinated an anti-smoking-ban petition that was presented to management. Patients had attended Patient Partnership Group meetings during 2011 and had discussed the possibility of legal action being taken against implementation of the ban. The respondents' decision to implement the comprehensive ban had been communicated to patients by notice displayed in all wards from 1 September 2011. The message had been repeated in notices issued on 8 and 15 September 2011. The nature of the revised partial ban, which was implemented from 21 September 2011, was notified to patients on 22 September 2011 and on two subsequent occasions.

[20] Surprisingly, the petitioner claimed to have been unaware of the respondents' intention to implement a comprehensive ban "for a substantial time" after the decision of 25 August 2011. The petitioner accepted, however, that he had been aware of the intended ban for some 5 or 6 weeks before 1 December 2011 (ie in October 2011), although he averred that he had not been provided with reasons for the decision. The petitioner instructed law agents on 8 March 2012; legal advice and assistance provision being made available effectively from 10 April 2012. The petitioner's claim was first intimated to the respondents on 3 May 2012. On 31 May, the petitioner applied for legal aid to institute proceedings. He was granted legal aid, after a review procedure, on 12 November 2012. A petition was duly presented on 30 November 2012. It is one of a number of petitions from different patients.

The Lord Ordinary's Decision

[21] The Lord Ordinary's Opinion was described at the hearing as akin to a well woven tapestry, with the threads of its reasoning prevalent throughout its whole surface. It is in highly discursive form. The Lord Ordinary first repelled the respondents' plea of *mora*, taciturnity and acquiescence. Adopting a relatively favourable approach to the petitioner's averments, he took the view that the petitioner had perhaps delayed instructing a law agent for only 3 months or so after he had become aware of the respondents' intention to introduce the comprehensive ban. Even then, he was not in a position to know what the reasoning for the decision had been, other than by accessing the joint policy document of the respondents and the NHS, which was published on the internet in February 2012 ("*Working towards a smoke free environment: an account of the journey taken by The State Hospital*").

[22] It is clear from his summary that the Lord Ordinary considered (Opinion para [1]) that the principal initial issue which taxed him was whether the 2003 Act empowered the respondents "to detain patients and to decide on the conditions of their detention". He reached the view (para [4]) that the legality of the prohibition on smoking turned upon the source of the respondents' power to impose such a prohibition. If this source were the 2003 Act, the next question was whether the respondents had complied with the 2003 Act principles "in relation to" patients and whether the reasoning for the decision had been adequate. He determined that the prohibition was unlawful (para [6]) because the respondents ought to have assessed the petitioner's situation "individually". It is implicit from his summary, and clear from later passages in the Opinion, that his view was that the failure to do so breached the petitioner's human rights, although a declaration to that effect rather than damages was "just satisfaction". Central to the Lord Ordinary's reasoning was his opinion that, once

compulsion and restriction orders have been made in terms of the 1995 Act, the terms of that Act cease to be relevant and the patients' care comes to be regulated by the 2003 Act.

[23] The Lord Ordinary reasoned (at para [26]) that:

> "The existence of a power to detain, confided to hospital managers, has to be deduced, rather like the existence of the Higgs boson, not from direct observation but indirectly from observation of its interactions with other functions."

On what he characterised as "this not very satisfactory basis", he was prepared to conclude (para [27]) that, by necessary implication, the 2003 Act gave power to the respondents to detain patients who were committed to the State Hospital, and that, by implication, in detaining patients and doing anything incidental thereto, such as addressing the issue of food parcels (*L v State Hospital* 2011 SLT 233) or smoking, the respondents were discharging a function by virtue of the 2003 Act (para [27]) and thus required to comply with the terms of sections 1(3) and (4) thereof.

[24] The Lord Ordinary considered that the 2005 Regulations suggested that the 2003 Act's least restrictive philosophy applied to all aspects of the regime under which patients were detained (para [35]). He also thought (paras [36] and [41]) that the respondents had, in any event, considered themselves bound to comply with the 2003 Act principles whenever they exercised a function in relation to adult patients (para [39]). This was based in part on the paper, namely "*Working towards a smoke free environment etc.*" (*supra*), which referred to the 2003 Act introducing requirements to ensure the appropriateness of accommodation. It was also based upon the fact that individual care plans had been devised to cater for smoking needs. This, the Lord Ordinary reasoned (para [38]), pointed to the respondents thinking that the 2003 Act principles did apply. This reasoning was, in turn, supported by a concession made by the respondents to this effect in an unrelated litigation (*L* v *State Hospital (supra)*).

[25] The Lord Ordinary went on to declare that the respondents' policy of a comprehensive smoking ban and a prohibition of tobacco products breached the petitioner's rights under Articles 8 and 14. He emphasised, however, that there was no "right to smoke" in a legal sense and that he did not endorse a "human right to smoke" (para [5]). The Lord Ordinary found (para [55]) that Article 8(1) was engaged. He agreed (para [50]) with Lady Dorrian's reservations in *L* v *State Hospital* (*supra*) about the decision of the majority in *R(N)* v *Secretary of State for Health* [2009] HRLR 31 (p 927) to the effect that a prohibition on smoking did not engage Article 8(1). Rather, the issue ought to be whether the interference could be justified as necessary and proportionate in terms of Article 8(2). The majority's reliance (*ibid*, para 61) on Lord Bingham's *dictum* (*Kay* v *Lambeth LBC* [2006] 2 AC 465, at para 36) that public authorities could manage and control their land as they saw fit was misplaced standing the European Court's view that public authority landlords were bound by Article 8 (*Kay* v *United Kingdom* (2012) 54 EHRR 30). Article 8(2) did not authorise "lifestyle fascism" (para [52]) whereby smoking could be prohibited (*Pretty* v *United Kingdom* (2002) 35 EHRR 1, at para 62). The respondents did not maintain that they required to prohibit smoking; thus, the Lord Ordinary reasoned, they accepted the legitimacy of patient choice. In any event, if, as he had concluded, the respondents had failed to comply with the 2003 Act principles, their intervention was not "in accordance with the law".

[26] On Article 14, the Lord Ordinary held that it was appropriate to use, as a relevant comparator, the Scottish Ministers' responsibility for the management of prisons, given that mental health detainees and penal detainees shared the same defining characteristic; being "in enforced residence" (para [59]). Given that adult prisoners may smoke in certain cells (Prisons and Young Offenders Institutions (Scotland) Rules 2011, rule 36) and in the open air, there had been discrimination on the ground of the petitioner's "other status" (para [60], under reference to *Clift* v *United Kingdom* (App no 7205/07), unreported, 13 July 2010). The only issue left was

whether the discrimination could be justified.

[27] Having looked at various policy documents, including "*Working towards a smoke free environment etc.*" (*supra*), which referred to the intention always being to create a "smoke-free environment with no provision for smoking internally or externally", and to the minutes of, and papers presented at, the respondents' meetings, the Lord Ordinary concluded that the end result was "always a foregone conclusion" (para [85]). Whilst the respondents claimed that there were difficulties with safety and security, together with operational and clinical disruption associated with the partial ban, the petitioner insisted that there had been no problems with his use of grounds access for smoking after the implementation of the revised partial ban on 21 September 2011. On the understanding that both parties were correct, the Lord Ordinary concluded that there was no rational basis for the respondents to have prevented the petitioner from smoking in the hospital grounds. There was no evidence of any consultation after that date (para [90]).

[28] The Lord Ordinary considered that the respondents' decision to build a smoke-free hospital was "questionable" in the light of the prevailing legal and policy context (para [119]). By doing so, the respondents had put it beyond their power to avail themselves of the statutory exemption allowed to psychiatric hospitals under the anti-smoking legislation. The legitimate aim of the state's interference with the right to smoke was to protect others against second-hand smoke, but not to stop smokers from smoking. Thus, the legislation recognised the need for exemptions to allow smokers to smoke, in a controlled way, in otherwise no-smoking premises that were to be treated as their "home" by reason of their enforced detention. There was nothing in national policy to indicate that it countenanced the achievement of a comprehensive smoke-free environment for potentially exempt groups (para [123]). The Lord Ordinary inferred (para [123]) that:

> "the smoke-free policy has been imposed on mental health detainees and not on penal detainees simply because the latter are in a position to defend their smoking habit whereas the former are not."

[29] The Lord Ordinary concluded, though with reluctance, that the decision to compel the petitioner to stop smoking was "flawed in every possible way" (para [124]). The decision was contrary to the national policy which it purported to implement. It was made without reference to the 2003 Act principles. Whether or not it was a legal requirement, the consultation had been embarked upon and had to be carried out properly. It had not been a meaningful exercise (*L* v *State Hospital (supra)*, Lady Dorrian at paras [6] and [24]; *R* v *Brent LBC ex p Gunning* (1985) 84 LGR 168; *R* v *North and East Devon Health Authority, ex p Coughlan* [2001] QB 213).

[30] The respondents had failed to justify the interference with the petitioner's rights under Article 8. The interference was not lawful, because it was not made in accordance with the 2003 Act principles and because it went further than was necessary to achieve the legitimate aim in question, namely to protect third parties from the petitioner's smoke (para [126]). Further, the respondents had failed to demonstrate an "objective and reasonable justification" for treating the petitioner differently from long-term prisoners. In the absence of a comprehensive statutory prohibition on smoking in psychiatric hospitals in general, or the State Hospital in particular, it was not appropriate to seek to enforce such a ban by extra-statutory means.

[31] The Lord Ordinary accepted that the petitioner had been deprived of one of his few pleasures. He had dwelled on his inability to smoke and had felt frustrated and aggrieved. However, he must also have gained significant health benefits and saved a lot of money. In these circumstances, a finding of breach of the petitioner's rights was just satisfaction (*Greens Petr* 2011 SLT 549; *Vento* v *Chief Constable of West Yorkshire Police* [2003] ICR 318; *Da'Bell* v *National Society for the Prevention of Cruelty to Children* [2010] IRLR 19), particularly given that the respondents' decision was to be reconsidered as a consequence.

Grounds of appeal, answers and cross-appeal

[32] The respondents advanced 5 grounds of appeal. The Lord Ordinary had erred in: (i) repelling the respondents' plea of *mora*, taciturnity and acquiescence; (ii) holding that the respondents did not have the power to implement the prohibition on smoking under the 1978 Act and that it had been "discharging a function by virtue of" the 2003 Act; (iii) holding that Article 8 of the Convention was engaged or, if it was, that there had been disproportionate interference with the petitioner's rights; (iv) holding that the relevant comparator for the purposes of Article 14 was a prisoner and that there was no reasonable and objective justification for a difference in treatment on that basis; and (v) concluding that the respondents' decision was contrary to the 2003 Act principles, defective as to its character and quality, and contrary to the national policy which it purported to implement.

[33] The petitioner cross-appealed in respect of his entitlement to an award of damages in just satisfaction for the breach of his Convention rights. In relation to ground of appeal (v), the respondents' decision had contravened the principle of non-discrimination contained in section 1(3)(g) of the 2003 Act.

Submissions

The respondents

(i) Mora, taciturnity and acquiescence

[34] There was a public interest in the prompt determination of the validity of the decisions of public authorities (*O'Reilly* v *Mackman* [1982] 3 All ER 1124). A successful plea of *mora*, taciturnity and acquiescence required all three elements (*Portobello Park Action Group Ass* v *Edinburgh City Council* 2013 SC 184; *Somerville* v *Scottish Ministers* 2007 SC 140 and *United Co-Operative* v *National Appeal Panel* 2007 SLT 831).

[35] The respondents had established all elements of the plea. The partial and comprehensive smoking bans and the intended timetable for their implementation had been known to the petitioner in advance. The petitioner had done nothing to challenge the comprehensive ban until some 5 months after it had taken effect. Other patients had intimated claims in November and December 2011. It was accepted that those other actions, which remained live, might proceed notwithstanding the upholding of the plea.

(ii) The nature of the power being exercised

[36] The State Hospital was a hospital within the National Health Service. The power to prohibit smoking was conferred on the respondents by section 102 of the 1978 Act, which was the principal governing statute for the NHS, and the 1995 Order, in terms of which the management of the State Hospital was delegated to the respondents (1978 Act, s 2). The totality of functions under section 102 was delegated to the respondents in unqualified terms (1995 Order, para 4(1)(a)).

[37] The power to manage the State Hospital was distinct from the power to detain patients there; the basis for the latter being orders of the court or the Mental Health Tribunal under a range of statutory provisions (eg 1995 Act, s 57A). The detention of patients was not a function discharged by the respondents "by virtue of" the 2003 Act (*G* v *Scottish Ministers* 2014 SC (UKSC) 84, Lord Reed at paras 23 – 27). The discharge of a function "by virtue of" the 2003 Act would require the 2003 Act to be the source of the function or power, which would have to be used "in relation to a patient". The 2003 Act made no provision for the management of hospitals.

[38] Where compulsion was involved, such as in the administration of medical treatment, specific authorisation directed towards a particular individual was required in terms of the 2003 Act (s 133). Management on the other hand comprehended the provision of buildings and facilities and the general conditions of the hospital, including catering and staffing arrangements, the way in which patients and staff interacted at a general level for reasons of security, and the conditions applicable in allowing patients to have

grounds access. Those were matters affecting patients, but at a level of generality that fell within section 102 of the 1978 Act. An analogous distinction could be drawn between the management functions of the respondents and the therapeutic functions of the clinicians.

[39] If the respondents had been discharging a function by virtue of the 2003 Act, it was accepted that they required to impose the minimum restriction on patients that was necessary having regard to the circumstances (*G* v *Scottish Ministers* (*supra*)) including the health and welfare of other patients and staff. The petitioner's freedom was not to be prioritised over other considerations (*ibid*, Lord Reed at paras 25 – 27). The respondents were required to undertake a balancing exercise taking account of the wishes of the petitioner and the health benefits to the other patients and staff (2003 Act, ss 1(3) and (4)). The respondents had complied with the section 1 requirements, albeit inadvertently.

[40] Whilst the context in which the smoking ban was implemented was the move to the new buildings, a comprehensive ban was not inevitable; only indoor smoking had been designed out of the new buildings. The respondents' decision on 25 August to implement a comprehensive ban had to be understood in the context of the prior decision of 23 June to implement the partial ban. The earlier decision had allowed smoking in designated external areas and had been reached on a considered basis. It was relevant to consider the practical difficulties experienced by the respondents in implementing the partial ban (*ibid*). The respondents had approached the matter with an open mind, informed by their experience of implementing the partial ban.

[41] The respondents' decision to adopt a comprehensive ban was consistent with national policy. The Lord Ordinary had erred in concluding that it was wrong as a matter of "law and policy" (para [119]) to insist on a comprehensive ban in circumstances where patients would be compelled to stop smoking, rather than be allowed to smoke in a controlled way.

(iii) Articles 8 and 14 of the European Convention

[42] The petitioner's rights under Article 8 were not engaged by the smoking ban (*R(N)* v *Secretary of State for Health* [2009] HRLR 31 (p 927); *R (Countryside Alliance & Ors)* v *Attorney General* [2008] 1 AC 719). The State Hospital was to be treated as the petitioner's home, but not in all respects as if it were a private home.

[43] Whether or not the smoking ban was a necessary incident of the management of the hospital, it was a proportionate interference with the petitioner's rights. The respondents' decision had been made pursuant to the general duty and legitimate aim to promote the health of patients and staff (1978 Act, s 2A(3) and (4); *R(N)* (*supra*), Clarke MR and Moses LJ at para 66). It was relevant to take account of the security and restrictions on liberty required for the detention of any patient in the State Hospital, whatever the precise nature of the order authorising detention. It was necessary for the respondents to have regard to the interaction of smoking with medication, in particular clozapine prescribed for the treatment of schizophrenia that was otherwise treatment-resistant.

[44] The petitioner's rights under Article 14 were not self-standing and arose only if Article 8 were engaged. For the purposes of Article 14 it was accepted that, the petitioner ought not to have been treated differently from other persons in relevantly similar situations without objective and reasonable justification (*DZ* v *Czech Republic* (2008) 47 EHRR 3). The relevant comparator was a patient at another high security hospital. There being no other such hospital in Scotland, the natural comparators were the 3 facilities in England, all of which had comprehensive smoking bans in force. If it were correct to confine any comparison to Scotland, then the 3 medium secure clinics would be the next best comparator, but the position was more complex than it had been before the Lord Ordinary. Whilst smoking was previously permitted in the grounds of those clinics, it had been decided in 2011 to implement a comprehensive smoking ban in Rowanbank. It was not appropriate to draw a comparison with prisoners. They were not detained by reference to the

criterion of mental disorder. The respondents were not to be treated as a proxy for the Scottish Ministers, contrary to the Lord Ordinary's decision, despite the issue not having been raised before him. The Scottish Ministers were not a party to the action, nor were they managers of the State Hospital.

(iv) The petitioner's cross-appeal

[45] The alleged breach of the petitioner's rights was the deprivation of an opportunity to undertake a voluntary act, where this interfered with the rights and freedoms of others and which also conferred a health benefit on the petitioner (cf *Greens, Petnr* 2011 SLT 549). Where there had been no pecuniary loss or physical harm to the petitioner, and no unlawful deprivation of liberty or detention in unsanitary conditions, declarator of a breach was just satisfaction.

The petitioner

(i) Mora, taciturnity and acquiescence

[46] Any delay by the petitioner did not constitute *mora*. The reasonableness of the delay had to be measured with regard to the complexity and difficulty of the case (*Portobello Park Action Group Ass* v *Edinburgh City Council* (*supra*)). The petitioner was disadvantaged in making a legal claim by virtue of his detention. The petitioner had persistently opposed the comprehensive ban, albeit not by way of formal correspondence. He had not been taciturn, nor was it appropriate to infer acquiescence in the circumstances. There was clearly an "ongoing issue", and the respondents cannot have been under the impression that nothing was going to happen. The decision under challenge would have effect for the foreseeable future (cf *Watt* v *Secretary of State for Scotland* [1991] 3 CMLR 429). There would be no prejudice or substantial difficulty caused to the respondents if the decision were to be reversed.

(ii) The nature of the power being exercised

[47] The respondents' decision had been taken in the exercise of a function under section 1 of the 2003 Act (*L* v *State Hospital (supra)*). Alternatively, the respondents were exercising their power in terms of both the 2003 Act and the 1978 Act. The 1978 Act provided for the respondents' management of the State Hospital and the 2003 Act provided for the petitioner's continuing detention, albeit that the petitioner's original detention had been authorised by virtue of a court order.

[48] The 2003 Act had been intended to make comprehensive provision for the care and treatment of the mentally disordered subject to the guiding principles contained in section 1. It would be contrary to that intention if that did not include the respondents' decision. The intention was that the managers would exercise their powers under the 1978 Act in a manner in accordance with the mental health legislation from time to time in force (*RM* v *Scottish Ministers* 2013 SC (UKSC) 139, Lord Reed at paras 46 – 47). Where a specific power existed, it was to be utilised in preference to a general power (*Richards* v *Richards* [1984] AC 174, Lord Hailsham at 199 – 200). Thus the provisions of the 2003 Act took precedence over those of the 1978 Act.

[49] As the petitioner was compelled to remain in the State Hospital, anything done there in the exercise of the respondents' management powers was an exercise of a function in respect of the petitioner in terms of section 1 of the 2003 Act. The 2003 Act principles did not apply to all management powers; only those exercised in the management of patients and the "conditions of their detention" (Lord Ordinary's Opinion, para [1]; *Julius* v *Lord Bishop of Oxford* (1880) 5 App Cas 214, Lord Cairns LC at 222 – 223, cited in *RM* v *Scottish Ministers (supra)*). Notwithstanding that there was a distinction to be drawn between the therapeutic and administrative functions of the respondents, whether the petitioner was allowed to smoke was a matter concerning his treatment in the broad sense (see 2003 Act, s 329).

[50] As a matter of common law, the exercise of a statutory power had to be informed by relevant considerations, including cross-reading the 2003 Act over to the exercise of powers under the 1978 Act (*Julius* v *Lord Bishop of Oxford (supra)*) even though, on a strict interpretation, the 2003 Act principles did not apply to the 1978 Act. The common law approach to the preservation of personal liberty (*S* v *McC, W* v *W* [1972] AC 24, Lord Reid at 43) also supported the application of the protection afforded by the 2003 Act principles.

[51] The respondents had failed to have regard to the 2003 Act principles and to provide proper reasons. No reference to the principles, or their content, had been made in the minutes of the respondents' meetings. The outcome of the consultation process had been a foregone conclusion. Where a consultation exercise had been carried out, it had to be undertaken properly whether or not there was a legal requirement to consult in the first place.

[52] There were no apparent difficulties in permitting the petitioner and other patients with grounds access to smoke outside. It was not sufficient for the ban to fall within a range of reasonable alternatives. The respondents were required to act rationally in determining the least restrictive course of action. A comprehensive smoking ban went beyond the existing public statutory regime. There was no evidence in the available policy documents that coercion or compulsion not to smoke was intended. The general policy was to allow smoking in the open air and to support and encourage people to stop smoking voluntarily.

(iii) Article 8 and 14 of the Convention

[53] Whilst the State Hospital was properly regarded as the petitioner's home, the right to quiet enjoyment of his home was distinct from the right to respect for his private life. It was only necessary to bring the smoking ban within one of those two categories. The imposition of compulsory measures to protect persons from harmful or dangerous activities, or the consequences of their chosen lifestyle, impinged on their private lives within the meaning of Article 8 (*Pretty* v *United Kingdom* (2002) 35 EHRR 1, para 62). The notion of private life included both physical and psychological integrity and, of particular importance, personal autonomy (*Munjaz* v *United Kingdom* [2012] MHLR 351, paras 78 – 80). The concept of personal autonomy was nebulous and its nature was not entirely clear, but it could be said to be the "right to live life in the manner of one's choosing". The smoking ban, or the choice to smoke, was an issue concerning the petitioner's personal autonomy (*R(N)* v *Secretary of State for Health* (*supra*), Clarke MR and Moses LJ at para 46, Keene LJ at paras 94 and 104). Any restriction of the petitioner's rights had to be subject to particular scrutiny in the light of his already limited personal autonomy (*Munjaz* v *United Kingdom* (*supra*); cf *R(N)* v *Secretary of State for Health (supra)*). The necessary incidents of the petitioner's detention would be authorised in terms of Article 5 and, to that extent, they would not engage Article 8. However, the smoking ban was not a necessary incident of the deprivation of liberty. Accordingly, the smoking ban engaged the petitioner's Article 8 rights and the interference had to be justified.

[54] Where the petitioner's Article 8 rights were engaged, a successful challenge to the lawfulness of the smoking ban under domestic law would also constitute a breach of Article 8(1). Otherwise, there were a number of factors to suggest that a comprehensive smoking ban was disproportionate in terms of Article 8(2). A comprehensive ban, which went beyond what was legally required, was disproportionate (cf *R(N)* v *Secretary of State for Health (supra*), Clarke MR and Moses LJ at para 77). The general policy underlying the domestic law was largely concerned with where and when individuals chose to smoke, according to the dangers of second-hand smoke. It was concerned with supporting individuals to make the choice not to smoke, rather than forcing them to make that choice. There was no evidence to suggest that anybody would be made subject to second-hand smoke, if the petitioner were to smoke outside.

[55] For the purposes of Article 14, the petitioner's mental disorder was a protected status (*Clift* v *United*

Kingdom (App. no 7205/07), unreported, 13 July 2010, at paras 55 – 61; *Kiss* v *Hungary* (2013) 56 EHRR 38, at para 42). The petitioner was in a similar position to someone detained in a prison in Scotland. Alternatively, the petitioner was to be compared with a patient detained in a less secure hospital (*ibid*, and at para 66; *R(N)* v *Secretary of State for Health (supra)*), in which case the relevant protected status was dangerousness. It was irrelevant that those institutions were administered by different public bodies. The proper focus was on the nature of the treatment administered at the hands of the State and not the identity of the administrative body. Otherwise, the effect of Article 14 could be circumvented by the creation of separate agencies amongst which discriminatory policies could be administered. An individual was entitled to compare himself with others who were the subject of treatment at the hands of any public authority within a particular jurisdiction. It was not appropriate to draw comparisons with other jurisdictions, including England and Wales, where different legislation applied (eg *Magee* v *UK* (2001) 31 EHRR 35, at para 50). The proper approach was to look at persons in analogous situations and to consider whether any difference in treatment was justified (*AL (Serbia)* v *Secretary of State for the Home Department* [2008] HRLR 41, Baroness Hale at paras 24, 25 and 28, applied in *R(N)* v *Secretary of State for Health (supra*), Clarke MR and Moses LJ at paras 58 - 59). In any event, section 1(3)(g) of the 2003 Act was intended to prevent discrimination (*G* v *Scottish Ministers (supra*), Lord Reed at para 17). Contrary to that principle, and without justification, the petitioner had been discriminated against.

(iv) The petitioner's cross-appeal

[56] The petitioner sought an award of damages in respect of his feelings of frustration and upset. As a matter of policy, he was entitled to a level of award that afforded proper recognition of the injury to his feelings (*Vento* v *Chief Constable of West Yorkshire Police* [2003] ICR 318). The petitioner had been particularly frustrated at the discriminatory element of being prevented from smoking outdoors, as well as more general frustrations associated with not being able to smoke at all. It was within the Lord Ordinary's discretion to refuse to make an award, but where an award was made, it ought to be at least £500 (*ibid,* Mummery LJ at para 65). There was no justification for "offsetting" any health or financial benefits of the smoking ban against the infringement of the petitioner's rights. The Lord Ordinary had erred to the extent, if any, that he had offset these factors.

Decision

(i) Mora, taciturnity and acquiescence

[57] In *Portobello Park Action Group Ass* v *Edinburgh City Council* 2013 SC 184 an Extra Division reviewed the principles that applied to a plea of *mora* in the context of judicial review, where there is not, as yet, a formal time limit for the presentation of a petition (see generally the Report of the Scottish Civil Courts Review – the Gill Review – (September 2009), ch 12, para 25 *et seq*; Courts Reform (Scotland) Bill 2014 s 85, inserting s 27A "Time Limits" into the Court of Session Act 1988). The Division, in essence, followed the First Division in *Somerville* v *Scottish Ministers* 2007 SC 140 to the effect that all three elements required to be established before the plea could be sustained. Whether there has been delay, in the sense of a lapse of time beyond what is reasonable, depends upon the particular facts and circumstances. Taciturnity involves a failure to assert a claim, when a reasonable person would do so. Acquiescence is an assent to a state of affairs inferred in an objective manner from inaction and silence.

[58] None of the three elements has been made out. It was apparent throughout the period from 25 August 2011, when the critical decision to implement a ban was made, through to its implementation on 5 December 2011, that a legal challenge, along the lines adopted in *L* v *State Hospital* 2011 SLT 233, was in the offing. It is true that the petitioner refrained from consulting a law agent until 8 March 2012, but he did not have the same

freedom of movement to do so as someone who is not detained. Throughout this period and beyond, there is nothing in the material to suggest that the smoking lobby, including the petitioner, had ceased its protestations or decided to assent to the imposition of the ban. After intimation of the petitioner's claim on 31 May 2012, the petitioner did nothing to suggest to the respondents that he was giving up his claim. Indeed, thereafter, he was actively engaged in securing legal aid to pursue it. In all these circumstances, the respondents' averments are insufficient to support the plea. The reclaiming motion, in so far as it seeks to reverse the Lord Ordinary's repelling of the respondents' first plea-in-law, must fail.

(ii) The nature of the power being exercised

[59] The State Hospital has operated as the institution responsible for the care and treatment of convicted persons who suffer from mental disorders since 1957, when a cohort of persons was transferred from Perth prison. The Mental Health (Scotland) Act 1960 empowered the courts to make hospital (s 55) and restriction (s 60) orders; the latter providing that the patient remain liable to be detained by virtue of the order until discharged by the Secretary of State (s 61). The making of a hospital order was sufficient authority (s 58) to convey the patient to the hospital and for the "board of management of the hospital to admit him … and thereafter to detain him" in accordance with the provisions of that Act. These provisions became, for the most part, incorporated into the Criminal Procedure (Scotland) Act 1975 (ss 175 and 178, 376 and 379), except that the authority to convey and detain was inserted into the Mental Health (Scotland) Act 1984 (s 60).

[60] The general provisions were, in due course, reconsolidated in the Criminal Procedure (Scotland) Act 1995 (ss 57, 58 and 59), but the specific section explaining the effect of a hospital order remained in the 1984 Act. That section was repealed by the Mental Health (Care and Treatment) (Scotland) Act 2003, but significantly it was not wholly replaced. Rather the new compulsion order, introduced by section 133 of the 2003 Act as section 57A of the 1995 Act, would itself authorise the detention (s 57A(8)), although specific provision was made concerning the removal of the offender to the hospital (s 57B).

[61] The significance of all of this is that it is the court that authorises the detention of the patient under the statutory powers available to it. The continued detention of the patient is by virtue of the court order, which remains extant until such time as it is revoked under the provisions of the 2003 Act following a review by the patient's responsible medical officer (s 182), a report to the Scottish Ministers (s 183), a reference to the Mental Health Tribunal (s 185) and revocation by the Tribunal (s 193). The continued detention of an individual is not authorised by the terms of a statute, but by order of the court, albeit under statutory powers.

[62] At the same time as it was introducing reforms to the procedures by which mentally disordered convicts could be detained in hospital instead of prison, the 1960 Act formally legislated (s 89) for the Secretary of State to be responsible for the provision of hospitals for these patients. It was section 90 ("Administrative provisions") of the 1960 Act that originally provided that the Secretary of State could, by order, constitute a committee to manage a State Hospital, subject to any directions which he might give. This committee would become the board of management (s 111). These provisions were consolidated in the 1984 Act (ss 90 and 91). However, the State Hospitals (Scotland) Act 1994 repealed the provisions. Instead, it provided (s 1) that the obligation to provide the hospitals and the vesting of their control and management in the Secretary of State, subject to his ability to delegate them to a Health Board, would rest not within the legislation specific to mental health but within the general NHS provisions in the form of a new section 102 of the National Health Service (Scotland) Act 1978.

[63] The significance of this is that, when the Millan Committee was asked to review the 1984 Act, the issue of the management of the State Hospital was not within its remit, since the relevant provisions had been removed from that Act and transferred into the 1978 Act. The Millan Committee report did not deal with

issues concerning that management and, consequently, the 2003 Act does not do so either.

[64] As already observed, the 2003 Act is an extremely detailed piece of legislation. What it concerns is not the general management of psychiatric hospitals, or the State Hospitals in particular, but the care and treatment of individual patients. It is focused upon the "definition of mental disorder; the criteria and procedures for detention in and discharge from hospital; leave of absence and care outwith hospital; …" (*supra*) (see generally *G* v *Scottish Ministers* 2014 SC (UKSC) 84, Lord Reed at para [3] *et seq*). Thus, as a relevant example of what it is about in the context of compulsory treatment orders (under s 64), it specifies that these may require the detention of a patient in hospital, the medical treatment of that patient, the attendance of the patient for the purposes of community care and other matters concerning his care and medical treatment. It allows scope for reviewing this type of order, not by the courts in a process for judicial review, but by the patient's responsible medical officer and the Mental Health Tribunal.

[65] There is a distinction to be made between the care and treatment of a particular patient, including the conditions of security under which that patient is detained, and the general management of a hospital. The latter function is carried out by the respondents in terms of the general powers contained in the 1978 Act. In the absence of evidence that smoking is a component part of the petitioner's medical care plan, the issue of whether he, or any other patient in the State Hospital, should be permitted tobacco or allowed to smoke, in areas not covered by the general legislative smoking ban, is a matter for the respondents exercising their powers of management under the 1978 Act. It does not involve the discharge of a function under the 2003 Act. It is not a decision "in relation to *a* patient" as envisaged in section 1 of that Act. Accordingly, there was and is no need for the respondents to apply the principles contained in that section.

[66] It follows that the concession made by the respondents in *L* v *State Hospital* (*supra*), to the effect that (para [5]) "in making decisions about the management and welfare of patients" the respondents were under a duty to apply the 2003 Act principles, was not wholly accurate. It is only when the decisions concern the care and treatment of particular patients (in relation to their psychiatric state) or their conditions of security and related matters as covered by the 2003 Act, that these principles must be applied. Were it to be otherwise, very many, perhaps thousands, of management decisions which might affect one of many patients would require individual scrutiny according to the 2003 Act principles. These decisions would include the daily movements of the patients, in so far as these were subject to routine, and the furnishing and perhaps even the decoration of the wards. They could cover the content and timing of meals, educational programmes, recreation periods and all sorts of areas which involve the "management and welfare" of the patients as a generality. That is not what the 2003 Act is about. Furthermore, if it were, the effect would be, as here, that decisions affecting the general management of the hospital would require to be the subject of consultation with patients who may no longer be in the hospital at the time of implementation and yet would not have been subject to such consultation with patients newly admitted.

[67] In short, and at the risk of repetition, the decision about whether patients, or indeed staff and visitors, should be permitted to smoke within the boundaries of the State Hospital was, and is, one of management to be exercised under section 102 of the 1978 Act. The 2003 Act is not applicable. The Lord Ordinary was in error in this respect. The petitioner's fourth plea-in-law therefore falls to be repelled.

[68] For completeness, the Lord Ordinary was correct in holding that, if the 2003 Act principles did apply, they had not been complied with. Inadvertent compliance is a somewhat unusual concept, but no doubt it is theoretically possible. However, section 1 requires the respondents to have regard, for example, to the particular views of the petitioner and his particular circumstances. A general poll of all patients, which may have been responded to by the petitioner, does not suffice to meet a requirement to take account of his specific wishes.

[69] The terms of section 1A of the 1978 Act, under which it is the duty of the Scottish Ministers to promote the improvement of the physical and mental health of the people of Scotland have not been overlooked. Nor has the specific duty of a Special Health Board (s 2A), such as the respondents, to the same effect. Section 2A(4) provides that anything done by a Special Health Board in pursuance of that objective is to be regarded as done in exercise of the functions of the Scottish Ministers conferred on the Board by the order constituting the Board. This too would point away from the respondents' move towards a smoke-free environment being a function under the 2003 Act. However, in the absence of submissions on the point, no further view is expressed.

(iii) Common Law Unreasonableness and Reasons

[70] Although it is not easy to grasp everything that is being advanced on behalf of the petitioner in terms of his written pleadings, note of argument and oral submissions, he appears to be arguing that the respondents' decision was, as it was put, "irrational" and unsupported by adequate reasons. This proposition is underpinned by a contention that every decision made by a public authority (or indeed anybody; see eg *Crocket* v *Tantallon Golf Club* 2005 SLT 663, Lord Reed at para [30]), of whatever nature, can be challenged by a petition for judicial review to the Court of Session by an individual who is affected by it in some way. Were that to be so, presumably all the other persons also affected by it (eg in this case every patient, staff member or visitor) would have standing to resist the application (see RCS 58.8(2)).

[71] The supervisory jurisdiction is not so wide as to permit the court to intervene in every situation where someone is affected by someone else's decision. Traditionally, that decision had to be one where a person's civil rights or patrimonial interests were affected (*Crocket* v *Tantallon Golf Club* (*supra*), Lord Reed at para [34] following *McDonald* v *Burns* 1940 SC 376, LJC (Aitchison) at 383-4). Civil rights would include those contained in a contract or provided under the general law. However, in the field of public law, it is now said to be sufficient to raise a legal challenge if a petitioner can claim to be "directly affected" by the decision or have a reasonable concern about the matter (*AXA* v *Lord Advocate* 2012 SC (UKSC) 122, Lord Hope at para [63]). Since the decision in this case does seem to be one of public law, it is difficult to conclude otherwise than that this petitioner has standing to challenge by judicial review any management decision taken by the respondents which gives him a reasonable concern, even if it is not one affecting his civil rights or patrimonial interests. This appears to be the position even if there may be force in the view that a public authority has the same general rights to manage its property, and thus to control what is done on it, or brought onto it, by others, as any other person, albeit that its decisions will be subject to the rights of others under either domestic law or the Convention (see eg *Kay* v *Lambeth LBC* [2006] 2 AC 465, Lord Bingham at para 36; *Kay* v *United Kingdom* (2012) 54 EHRR 30 at para 74).

[72] The next question must therefore be whether the decision to implement the comprehensive smoking ban was lawful. Leaving aside the issue of any infringement of the petitioner's Convention rights for the moment, the focus must be on the decision making process rather than the merits of the decision itself (see eg *Stewart* v *Monklands DC* 1987 SLT 630, Lord Clyde at 632-633). Assuming that the decision was within the powers of the respondents, which it undoubtedly was, it is not for the court to review the merits of the decision and to substitute its own views, on the desirability of imposing a comprehensive smoking ban in the State Hospital, for those of the board of management, the members of which are in a far better position to gauge the merits.

[73] In assessing legality, the starting point may be the obligation on the respondents under the 1978 Act to promote the improvement of physical health. There are few who would now argue that preventing persons from smoking will not achieve that purpose. In this connection, however, there is an obvious difference between what a government might seek to achieve in society in general and what its health services or

hospital boards might do within the curtilage of their own properties or in their particular fields of endeavour.

[74] The Lord Ordinary was correct to say that Government policy did not involve preventing people from smoking by either introducing a prohibition on tobacco or stopping people from smoking in their own homes or in open spaces. The particular relevant exemption in the legislation permits there to be designated smoking rooms in psychiatric in-patient premises. However, the fact that the Government did not wish to legislate to criminalise smoking in such premises as a generality, for whatever reason, does not mean that the Government policy was one which positively approved of continued smoking in such premises or that it would be in favour of the provision of designated smoking rooms or outdoor facilities in the hospital environment. Rather the general tenor of the policy was to move towards a smoke-free environment and to encourage NHS Boards to take the lead in that move, where practicable to do so.

[75] It is not possible to agree with the Lord Ordinary's view (para 124) that the actings of the respondents were contrary to the Government's policy. That policy was not just to protect others against second-hand smoke, it was also to encourage smokers to stop smoking, albeit by methods short of total prohibition. It is equally impossible to agree with his view that the respondents' decision to build a smoke-free hospital was either questionable in terms of the legal or policy context or that it put it beyond their power to take advantage of the exemption for psychiatric institutions. The fact that there were no designated smoke rooms in the new buildings did not in fact prevent the respondents from allowing smoking outside or, if they had changed their minds, even creating such rooms. The expression of a desire to go completely smoke-free did not prevent the respondents from initially progressing only to a partial smoking ban or from reversing its original decision after *L* v *State Hospital* (*supra*) pending consultation and reconsideration. There was no fettering of a discretion to make a particular decision or indeed to alter one previously made.

[76] The process of moving towards a smoke-free hospital was entirely in accordance with Government policy to create a smoke-free Scotland by using reasonable means short of preventing persons from smoking in the privacy of their own homes. The fact that it was and is deemed prudent not to force the issue, by criminalising smoking in the open air, does not mean that the policy approved of that practice. The contrary is true given the initiative to move towards entirely smoke-free hospitals, including hospital grounds.

[77] In relation to the decisions made by the respondents over time, the determination to move to a smoke-free hospital was a decision which was within the range of reasonable decisions open to the respondents on the material presented to them. It was amply justified by the reasons recorded at the various meetings. The decision to build a new hospital without designated smoking rooms is not under challenge. The decision to move to a partial smoke-free policy is also not under challenge. Focus must therefore be upon the particular decision, which is challenged, namely that of 25 August 2011 to implement a comprehensive prohibition from 1 December 2011. The reason for that decision was that the partial ban had been deemed unworkable.

[78] Again, it is not appropriate for the court to go behind a conclusion reached by professionals, who are experts in the field, by saying, as the Lord Ordinary appears to have done, that a partial smoking ban was workable in so far as the petitioner's particular case was concerned. The idea that the petitioner alone in the State Hospital would be allowed to smoke, in the absence of any clinical imperative, is hardly a practical one given the likely reaction amongst the remaining smokers. The respondents required to reach a decision applicable as a generality to the hospital as a whole.

[79] A specific point was raised in relation to the consultation process, based on the principle that, if a public authority embarks upon such a process, those consulted have a legitimate expectation that the results of the process will be properly taken into account in the decision making process itself. Assuming that to be so, the respondents cannot be faulted in the manner in which the consultations were carried out and the way in which the results were factored into the reasoning behind the decisions. The respondents, whilst committing

themselves to proper consultation, did not advise that any decision to follow would be a democratic one based upon a majority of the patients' views.

[80] It is true that in October 2010 the respondents had previously decided that they would move towards a comprehensive smoking ban. However, they had reversed that decision after *L* v *State Hospital* (*supra*), reverted to a partial ban and proceeded to carry out a consultation between March and May 2011. They had received a report on the consultation from their chief executive. In June 2011, they had resolved to implement a partial ban subject to a review of its practicabilities. In August, the feedback exercise, which itself was a further consultation, resulted in the conclusion that the partial ban was unworkable. Hence, the respondents decided once more to implement a comprehensive ban. Contrary to the Lord Ordinary's view, there is nothing to suggest that the exercise had not been meaningful. On the contrary the information gleaned from the original consultation and the subsequent feedback were significant drivers in the decision making process.

[81] For what little it may be worth from a court's perspective, the respondents' ultimate decision is not difficult to understand. The partial ban was, naturally enough, causing problems with discrimination between those allowed grounds access and those without. If those without access were to be permitted to smoke, then it would have to be in the ward gardens. That caused disruption to routines, transformed the gardens into smoking rooms and created further discrimination problems as between wards. All of this has to be seen in a context in which it is recognised that a prohibition on smoking would produce substantial health benefits to mental health patients. The notion that a health institution ought to provide smoking facilities, and thus effectively damage their own patients' health, is perhaps a surprising one in the modern era. The reasons for the "gold standard" policy set out above are compelling. In all these circumstances, there is no reason to hold that the decision of the respondents, that in their hospital grounds there should be a no smoking regime, is unlawful because of the process adopted, or any irrationality or fault in the reasons given. The respondents' third and fourth pleas-in- law should therefore be sustained and the petitioner's seventh plea repelled.

[82] For completeness, the Lord Ordinary's view, that the smoke-free policy has been imposed on mental health detainees and not on prisoners because the latter are in a position to defend themselves and the former are not, appears to be without foundation, as the current proceedings themselves demonstrate.

[83] Furthermore, it would not have been appropriate, when imposing rules in relation to smoking, for the respondents to have invoked the powers available under the Mental Health (Safety and Security) (Scotland) Regulations 2005. These empower the respondents to carry out actions, such as searches or surveillance, which, but for the regulations, would be likely to be regarded as unlawful. A management rule about not permitting smoking on the premises is not in that category.

(iv) Article 8(1)

[84] In *Munjaz* v *United Kingdom* [2012] MHLR 351, the European Court of Human Rights, when examining a policy of seclusion at Ashworth Special Hospital in England, repeated its well established jurisprudence that:

> "78. The notion of a private life is a broad concept and covers, inter alia, the physical and psychological integrity of a person, the right to personal development and the right to establish and develop relationships with other human beings in the outside world. In addition, the notion of personal autonomy is an important principle underlying the interpretation of the guarantees of Article 8 (see *Pretty* v *United Kingdom* [(2002) 35 EHRR 1] at § 61).
>
> 79. In assessing the proper scope of private life for those who are deprived of their liberty, … under the Convention system, the presumption is that detained persons 'continue to enjoy all the fundamental rights and freedoms guaranteed under the Convention save for the right to liberty, where lawfully

imposed detention expressly falls within the scope of Article 5 of the Convention" (*Hirst* v *United Kingdom (no 2)* [(2006) 42 EHRR 41 at] § 69). Any restriction on those rights must be justified in each individual case (*Dickson* v *United Kingdom* [(2008) 46 EHRR 41 at] § 68)."

[85] These general principles must be applied to the present case. In doing so, however, the necessary implication in the quoted passages, that detained persons enjoy the same rights under the Convention as others except insofar as a restriction falls within the scope of lawful detention in terms of Article 5 or is a necessary consequence of such detention, has to be borne in mind. Thus, in *DG* v *Ireland* (2002) 35 EHRR 33 (at para 105), albeit in the prison context, the European Court remarked that there may be circumstances in which Article 8 can afford protection in respect of conditions of detention which do not attain the level of severity required by Article 3 (*Raninen* v *Finland* (1998) 26 EHRR 563, para 63). However, normal restrictions and limitations consequent on prison life do not infringe Article 8 either because they do not constitute an interference with the detainee's private life (*X* v *United Kingdom* (1982) 4 EHRR 118; *Raninen* v *Finland* (*supra*)) or because any such interference is justified (*Wakefield* v *United Kingdom* (App. No. 15817/89), unreported, 1 October 1990 (Comm)).

[86] Similarly, in *Kalashnikov* v *Russia* (2003) 36 EHRR 34 the Court observed (at para 95) that, for a breach of Article 3 to be established, any suffering or humiliation must go beyond that inevitable element connected with legitimate treatment or punishment. The context was whether conditions of detention violated the prohibition against inhuman and degrading treatment, but it is equally applicable to a consideration of whether conditions of detention violate the right to respect for private life under Article 8.

[87] In order to constitute a violation of Article 8, the conditions of detention founded upon must be more restrictive than those inherent in an otherwise lawful detention. Thus, the ultimate conclusion in *Munjaz* v *United Kingdom* (*supra* at para 82) was that the periods of seclusion complained of had to be regarded as additional interferences with the private life of the applicant which were distinct from the inevitable interference with his private life that arose from his detention in high security conditions at Ashworth.

[88] Whilst detainees continue to enjoy the right to respect for private and family life under Article 8, the scope of that right is necessarily restricted to protection from interference beyond that which inevitably flows from the circumstances of lawful imprisonment or other detention. Whether the conditions of detention are deemed not to infringe Article 8 because they fall within the scope of lawful detention under Article 5 and are thus outwith the scope of private life under Article 8(1), or because they are justified in terms of Article 8(2), may be of little practical import; the restrictions will have to be considered in either case (*Hirst* v *United Kingdom (supra),* para 69).

[89] The respondents properly exercised their general powers of management under section 102 of the 1978 Act (*supra*, para 79). The decision reached and implemented represents a restriction consequent upon the lawful detention of patients in terms of Article 5. The petitioner's right to respect for private life extends only to protection against interference beyond the concomitants of lawful detention. To that extent, the court endorses the approach of the court in *L* v *State Hospital* (*supra*, Lady Dorrian at para 25). Were it to be otherwise, then, similar to the position that would result if the 2003 Act principles were to apply, the respondents would be required to scrutinise countless management decisions which might affect one of many patients on the basis that *any* restriction on the private life of an individual patient must be independently justifiable (*Munjaz* v *United Kingdom* (*supra*), para 79). Without some restriction of the scope of the right to respect for a private life of detained persons to that beyond the ordinary restrictions pursuant to lawful detention, such institutions as the State Hospital would be unmanageable.

[90] This approach thus attempts to recognise the practical differences that necessarily and reasonably arise between life in a private home and life in an institutional environment. If the court is wrong, however, the

answer to the particular question of exactly what the Article 8 right to respect for either a person's home or private life entails in practical terms is one which is capable of engendering lengthy debate, analysis and expression. This ground has already been covered several times in recent years in a variety of different courts in relation to diverse activities, from assisted suicide to fox hunting. It is not necessary to revisit the extensive philosophical legal or political thinking on the proper scope of the general right requiring protection. It would also be unhelpful to try to rephrase the many sound *dicta* on the subject, thus adding to what appears to be some uncertainty on that scope in certain quarters. Rather, the court is inclined to confine itself to a consideration of the state of the law on the applicability of Article 8 as it bears directly upon the present circumstances.

[91] A succinct analysis of the English and European authorities was carried out by the Divisional Court (Pill LJ and Silber J) in *R(N)* v *Secretary of State for Health* [2008] HRLR 42 (p 1023). This was in relation to the statutory prohibition of smoking in Rampton Hospital in England; a situation not so far removed from the management decision to prohibit smoking in the present case. It is both convenient and sufficient to repeat certain short passages in the judgment of that Court as definitive of the current state of the law in England:

> "99. The concept of respect for private life and home life in article 8 requires respect for 'physical and psychological development', 'personal development and autonomy (*Pretty [*v *United Kingdom* (*supra*)]), 'physical and moral integrity' (*Raninen [*v *Finland* (*supra*), 'mental stability', 'integrity of a person's identity' ([R (] *Razgar* [) v *Secretary of State for the Home Department (no 2)* [2004] 2 AC 368) , 'protection of private sphere and private space' ([*R (*] *Countryside Alliance* [*)* v *Attorney General* [2008] 1 AC 719]).
>
> 100. We do not accept that the respect required by article 8 is coextensive with the right of absolute independence contemplated by John Stuart Mill. The law may place restrictions on a person's freedom of action without necessarily interfering with the right to respect required by article 8. The expression 'personal autonomy' used by [the European Court] in *Pretty*, undoubtedly resonates with the Mill philosophy but as Baroness Hale has stated in *Countryside Alliance*, at paragraph 116, the protection 'falls some way short of protecting everything they might want to do even in that private space'.
>
> 101. Preventing a person smoking does not, at any rate in the culture of the United Kingdom, generally involve such adverse effect upon the person's 'physical or moral integrity', or the other concepts cited above, as would amount to an interference with the right to respect for private or home life within the meaning of article 8. We do not accept the notion of an absolute right (subject to article 8(2)) to smoke wherever one is living. Nor, following the analysis of Lord Hope in *Countryside Alliance*, do references to the 'ambit' or 'scope' of article 8 introduce, via article 14, an application of article 8."

Having considered the differences between a private home, a care home and places where a person is detained under minimum or maximum security conditions, the court concluded that:

> "103. We are not persuaded that the requirement to respect for family life and home in article 8 imposes a general responsibility on those responsible for the care of detained people to make arrangements enabling them to smoke. Whether it is put in terms of moral integrity, identity or personal autonomy, no general right for mental patients to smoke, or general obligation to permit smoking, arises."

[92] When the Court of Appeal came to review the Divisional Court's approach ([2009] HRLR 31 (p 927)), the majority (Clarke MR and Moses LJ) rejected the idea that Article 8 protected a person from interference by the state with anything which he chooses to do within the privacy of his own home. The court considered that

whether the scope of Article 8 was broad enough to encompass a particular activity required consideration of a variety of factors. Ultimately, given the deep intrusion into a person's home and private life already created by the detention of a person in a mental hospital, the court was of the view (para 46) that there was "no basis for distinguishing between the loss of freedom to choose what one eats or drinks in such an institution and the ban on smoking". The majority accepted the applicability of the Article 8 right to a detained patient and (para 49) that activities which such a patient is able to pursue are all the more precious, given the other restrictions. However, looking at the previous jurisprudence:

> "the importance of smoking to the integrity of a person's identity [was] …not …sufficiently close to qualify as an activity meriting the protection of art. 8. It is some distance away from the examples considered in Lord Bingham's speech in *Countryside Alliance* and it is certainly not to be equated with the development of a patient's personality, as Lord Rodger understood that concept…".

[93] The fundamental proposition, which the majority of the Court of Appeal, agreeing with the Divisional Court, expressed (para 51) and which is both highly persuasive and ought ultimately to be endorsed, is that a comprehensive smoking ban does not, in such an institution, have a sufficiently adverse effect on a person's physical or psychological integrity or his right to personal development as to merit protection. Although addictive, smoking is essentially no different from the consumption of other products designed to sustain life or provide enjoyment or both. Many persons have cravings for different consumables from tea or coffee, alcohol in a variety of different forms, through to chocolate and other foodstuffs. However, in the context of an institution such as the State Hospital, it is a question for management to decide what is to be made available to the patients. A decision to prohibit a particular product, or brand of product, does not engage Article 8 such that every decision to do so requires to be justified in terms of Article 8(2) if a particular patient chooses to complain. No doubt, under the general duty of care owed to patients under domestic law, there requires to be an overall standard of provision which ensures that the health of the patients is not endangered but, in Convention terms, a decision to select or to prohibit, for example, a particular type or brand of consumable, different from the patient's favourite, does not engage Article 8 and the same principles apply to tobacco, or indeed alcoholic, products.

(v) Article 8(2)

[94] If, on the other hand, Article 8 were engaged, the issue would be whether the decision to prohibit smoking was in accordance with the law and necessary in a democratic society in the interests of public safety, the prevention of disorder or crime, for the protection of health and the rights and freedoms of others. For the reasons given relative to the non-application of the 2003 Act principles, the respondents' decision was in accordance with the law. The petitioner was lawfully detained under court warrant. The prohibition of smoking in the hospital was a lawful act carried out by the respondents as part of their general management powers conferred by section 102 of the 1978 Act and the State Hospitals Board for Scotland Order 1995.

[95] In *Kay* v *United Kingdom* (*supra*) the European Court re-iterated the general principles concerning the meaning of "necessary" in the context of Article 8. It stated:

> "65. An interference will be considered 'necessary in a democratic society' for a legitimate aim if it answers a 'pressing social need' and, in particular, if it is proportionate to the legitimate aim pursued. While it is for the national authorities to make the initial assessment of necessity, the final evaluation as to whether the reasons cited for the interference are relevant and sufficient remains subject to review by the Court for conformity with the requirements of the Convention [(*Smith* v *United Kingdom* (2000) 29 EHRR 493 at [88]; and *Connors* v *United Kingdom* (2005) 40 EHRR 9 at [81])].

66. In making their initial assessment of the necessity of the measure, the national authorities enjoy a margin of appreciation in recognition of the fact that they are better placed than international courts to evaluate local needs and conditions. The margin afforded to national authorities will vary depending on the Convention rights in issue and its importance for the individual in question. The Court set out its approach in *Connors* at [82], in which it stated:

> 'The margin will tend to be narrower where the right at stake is crucial to the individual's effective enjoyment of intimate or key rights... On the other hand, in spheres involving the application of social or economic policies, there is authority that the margin of appreciation is wide …(*Buckley* v *United Kingdom* [(1997) 23 EHRR 101)] §75 et fine)…'."

The Court noted also that there was a procedural question as well as one of substance in that courts are required to examine whether the decision making process leading to measures of interferences has been fair and such as to afford due respect to the interests safeguarded by Article 8.

[96] Here, of course, there requires to be a consideration by the court not only of the legality of the procedure leading up to the decision but of the merits of the decision itself relative to the Convention rights. For the reasons already explored in relation to the non-Convention based case of illegality, the process adopted by the respondents was a reasonable one, which gave due consideration to the views of the staff and patients of the hospital . It balanced those views with the material which stressed the negative side of smoking in terms of the health of both the smoker and those within his vicinity. Affording the respondents the courtesy of assuming that they know far more about the health of their patients than the courts do, the reasons given for the comprehensive ban within the grounds of a mental health institution are indeed that it answers a pressing social need to reduce the incidence of smoking, both generally and in health institutions in particular. It is proportionate to the legitimate aim of promoting the health of those detained and those at work. Once more, it would be surprising in the modern era if those tasked with the management of health services were not pursuing the smoke-free policies advocated by the Government, including that of going beyond the strict terms of the legislation and seeking to secure a smoke-free environment, where that environment is directly under their management and control. The petitioner's fifth plea-in-law should therefore be repelled.

(vi) Article 14

[97] Since Article 8 is not engaged, its potentially discriminatory application under Article 14 does not now arise. If, however, Article 8 had been engaged, in assessing any form of discrimination, a comparison with prisons would not have been appropriate. The whole purpose of the compulsion and restriction order regime is to divert certain categories of offender, namely the mentally disordered, away from the prison setting and into that of a hospital, albeit a secure one. The reason for this is that prison is not considered to be an appropriate institution for such persons. Rather, they ought to be in a therapeutic environment and not one focusing primarily on confinement as a punishment. It must be borne in mind that the State Hospital does not only house those who have been detained under the criminal justice system but also others who have been deemed a danger to themselves or the public and require compulsory measures of mental health care.

[98] Prisons are managed under an entirely separate regime from hospitals, albeit that both are ultimately the responsibility of the Scottish Ministers. They are heavily regulated institutions, notably in the form of the Prisons and Young Offenders Institutions (Scotland) Rules 2011, which contain a myriad of different regulations covering levels of security, supervision, clothing and accommodation. There are rules, expressed in general terms, about the quality of food and drink (reg 35) and about smoking (reg 36). The latter permits

smoking, *inter alia*, in a single cell and in the open air. However, the petitioner is specifically not confined to a prison. Rather he is confined to a hospital, albeit a special one. If any comparison were appropriate for discrimination purposes, it would be with other hospitals.

[99] It is clear that there is no legislative requirement for the respondents to prohibit smoking throughout their hospitals. The Government have not introduced legislation which requires hospitals to prohibit smoking within their boundaries. However, it is clear that this is the intention in the relatively short term. The case of discrimination is not made out and petitioner's sixth plea-in-law should be repelled.

(vii) Damages

[100] There being no violation of Article 8 or 14, the question of damages does not arise. Had it been decided that the smoking ban had violated the petitioner's Convention rights, the decision of the Lord Ordinary, that a finding of breach alone was the just and appropriate remedy in the circumstances (Human Rights Act 1998, s 8(1)) and that it was not necessary to make an award of damages to afford the petitioner just satisfaction (1998 Act, s 8(3)), would have been upheld.

[101] It is not appropriate to conduct a paternalistic exercise of offsetting the financial and health benefits to the petitioner against the frustration and anxiety experienced by him as a result of being unable to smoke. However, there is a requirement to take account of all the circumstances of the case in order to determine whether an award is necessary (1998 Act, s 8(3)). The Lord Ordinary was entitled to observe the wider context in which the petitioner's claim for damages fell to be considered. Before this court, that context included the petitioner's recent transfer to a medium secure unit, where he was able to resume his smoking habit, albeit temporarily.

[102] In determining whether to award damages, and in assessing the amount of such an award, the court must take account of the European Court jurisprudence in relation to the award of compensation under Article 41 of the Convention (1998 Act, s 8(4)). Ultimately, the court is seeking to identify an equitable award, in broad terms, such as the claimant might be expected to receive from the European Court itself (*R (Greenfield)* v *Secretary of State for the Home Department* [2005] 1 WLR 673; *R (Sturnham)* v *Parole Board* [2013] 2 AC 254, Lord Reed at paras 13 and 24 – 40). It will not generally be appropriate to apply domestic principles on quantum of damages for a breach of a quasi delictual duty *(ibid;* cf Lord Reed at para 29). In the present case, no European jurisprudence was cited in respect of this aspect of the appeal. Instead, the petitioner sought to rely on guidelines in *Vento* v *Chief Constable of West Yorkshire Police* [2003] ICR 318, which concerned the appropriate scale of awards to compensate injury to feelings in the employment setting. Notably, it recommended that awards of no less than £500 be made, as otherwise an award would be regarded as "so low as not to be a proper recognition of injury to feelings" (*ibid,* Mummery LJ at para 65). In human rights cases, however, it is well-established that a finding of breach may be a significant remedy of itself, constituting proper recognition of any injury to feelings caused by a violation of Convention rights.

[103] Whether an award of compensation is warranted, in addition to a finding of breach, will depend on the circumstances of each individual case, including the duration and severity of any feelings of frustration and anxiety (*R(Sturnham)* v *Parole Board (supra*), Lord Reed at para 66). The petitioner advanced a broad claim in respect of his general frustration at not being able to smoke, although the focus of his claim was the prohibition of smoking outdoors as a consequence of the comprehensive ban. The relevant period runs from the implementation of the comprehensive ban until the petitioner's transfer to Rowanbank. The transfer took place on an unspecified date between the hearing before the Lord Ordinary in February 2013 and the hearing of this appeal in May 2014. It may be assumed that the court is concerned with a period of around 2 years following implementation of the comprehensive ban in December 2011.

[104] Whilst the Lord Ordinary observed that the petitioner had been deprived of one of his few pleasures during that period and had dwelled on his inability to smoke, the nature of the deprivation or the petitioner's feelings consequent upon it are not sufficiently significant to warrant an award of monetary compensation.

Conclusion

[105] The court should accordingly: allow the reclaiming motion; recall the interlocutor of the Lord Ordinary dated 27 August 2013; of new repel the respondents' first plea-in-law; repel the petitioner's first to tenth pleas-in-law; sustain the respondents' third to eighth pleas-in-law; and refuse the prayer of the petition.

SECOND DIVISION, INNER HOUSE, COURT OF SESSION

[2014] CSIH 71
P1265/12

Lord Justice Clerk
Lady Paton
Lord Brodie

OPINION OF LADY PATON

in the reclaiming motion

CHARLES McCANN

Petitioner and Respondent;

against

THE STATE HOSPITALS BOARD FOR SCOTLAND

Respondents and Reclaimers:

Act: Leighton; Drummond Miller LLP
Alt: K Campbell QC; NHS Scotland Central Legal Office

12 August 2014

[106] I agree with the opinion of your Lordship in the chair, with one exception, namely the question of article 8 of the European Convention on Human Rights (ECHR). In my opinion, smoking is such an addictive activity that it is very much part of an individual's "personal autonomy" (*R (on the application of N)* v *Secretary of State for Health* [2009] HRLR 31, the dissenting opinion of Keene LJ; *L* v *State Hospital* 2011 SLT 233 paragraphs [25]-[26]). Thus in my view, article 8 of the ECHR is engaged. However bearing in mind the nature of the mental disorders suffered by the patients in the state hospital, the fact that some of those patients have committed crimes, the types of item required for the purpose of smoking (for example, cigarette lighters and matches, both producing naked flames, and lit cigarettes with burning ends), the degree of organisation and supervision required to enable patients to smoke without harming themselves or others, the prejudicial effect for some patients of the interaction of the smoking and their medication, and the prejudicial effect of secondary cigarette smoke upon non-smokers including members of the hospital staff, I am satisfied that the ban on smoking

imposed by the respondents was necessary in the interests of public safety, the prevention of crime, and for the protection of health.

[107] In relation to article 14 of the ECHR, relevant comparators would, in my opinion, be other NHS hospitals and their patients, where smoking is completely banned. Accordingly I consider that there is no discrimination.

SECOND DIVISION, INNER HOUSE, COURT OF SESSION

[2014] CSIH 71
P1265/12

Lord Justice Clerk
Lady Paton
Lord Brodie

OPINION OF LORD BRODIE

in the reclaiming motion

CHARLES McCANN

Petitioner and Respondent;

against

THE STATE HOSPITALS BOARD FOR SCOTLAND

Respondents and Reclaimers:

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12 August 2014

[108] I concur with the opinion of the Lord Justice Clerk and agree that, for the reasons he gives, the reclaiming motion should be allowed.