



OUTER HOUSE, COURT OF SESSION

[2013] CSOH 143

P1265/12

OPINION OF LORD STEWART

in the Petition of

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fPetitioner;

for

Judicial Review of a decision on
25 August 2011 by the State Hospitals
Board for Scotland to ban smoking at the
State Hospital

and Answers for

The State Hospitals Board for Scotland

Respondents:

Petitioner: Leighton; Drummond Miller LLP
Respondents: K Campbell QC; NHS Scotland Central Legal Office

27 August 2013

[1] The Mental Health (Care and Treatment) (Scotland) Act 2003 has posed a number of interpretative challenges for the courts [*Scottish Ministers v Mental Health Tribunal for Scotland (MM)* 2010 SC 56; *Sherrit v NHS Greater Glasgow & Clyde Health Board* 2011 SLT 480; *DC Re Judicial Review* 2012 SLT 521; *RM v The Scottish Ministers (Scotland)* [2012] UKSC 58 (28 November 2012)]. The issue that taxes me on this occasion

is whether the 2003 Act empowers the managers of the State Hospital, Carstairs, to detain patients and to decide on the conditions of their detention. The State Hospital is of course a high security psychiatric hospital, the only one in Scotland. It serves Scotland and Northern Ireland. The question about the power of the hospital managers arises in connection with the complaint of a cigarette smoker who is detained indefinitely in the State Hospital. He is the petitioner; and he objects to the fact that the managers have decided to prohibit the possession of tobacco products and to prohibit smoking, not just inside the hospital but also in the hospital grounds to which the petitioner has the privilege of unescorted access during daylight hours. The hospital managers are the State Hospitals Board and they are the respondents to this petition.

[2] The decision to implement a comprehensive smoking ban was made by the respondents at their meeting of 25 August 2011. The ban took effect on 5 December 2011. The petitioner instructed solicitors on 8 March 2012. The solicitors intimated his claim on 3 May 2012. The solicitors then applied for legal aid to raise proceedings. Legal aid was granted, eventually, on 12 November 2012. The petitioner's application for judicial review of the smoking ban was presented on 30 November 2012 and first orders were granted on 5 December 2012. I heard submissions by counsel for the parties at a first hearing on 14 and 15 February 2013. Having made *avizandum* I have now decided that the petition should be granted in part.

The issues and the outcome: summary of the decision

[3] The petitioner asks the court to declare that the respondents' "policy of a complete smoking ban and prohibition of possession of tobacco products by patients at the State Hospital" is unlawful; and also to declare that the respondents' policy has breached the petitioner's human rights, specifically article 8 of the European Convention on Human Rights [ECHR] (right to respect for private life and home) as a stand-alone claim and in combination with article 14 ECHR (enjoyment of Convention rights without discrimination) and the first protocol, article 1 ECHR (right not to be deprived of property) as a stand-alone claim and in combination with article 14 ECHR (enjoyment of Convention rights without discrimination). The petitioner seeks to have the smoking ban and the prohibition on tobacco products set aside by reduction failing which by suspension. The petitioner also claims Convention damages for the breach of his rights in the sum of £3,000.

[4] The question of the lawfulness of the smoking ban turns, in the first place, on the source of the respondents' power to impose such a ban. Are they exercising a power in terms of the Mental Health (Care and Treatment) (Scotland) Act 2003? If the 2003 Act applies, the next question is whether the respondents have complied with the 2003 Act principles for decision-making "in relation to" patients? In

addition and in any event there is a question about the adequacy of the reasoning for the decision. The respondents say that the smoking ban is not a 2003 Act function and, if it is, that they have complied with 2003 Act principles. In any event the reasoning is adequate. The respondents also maintain that cigarette smoking in the State Mental Hospital is not an activity that attracts the protection of article 8 ECHR by itself or in combination with article 14 ECHR; and, if it does, the smoking ban is a necessary and proportionate response in pursuit of a legitimate health aim. The respondents simply deny any breach of the first protocol, article 1 ECHR. Before anything else the respondents maintain that the petitioner's claim is barred by delay, "*mora*, taciturnity and acquiescence" being the traditional formulation of the plea.

[5] I do not think that the *mora* plea is a good one and I have repelled it. Insofar as I have allowed the petitioner's application on the merits I have done so with a degree of reluctance. It is a perfectly reasonable proposition, given contemporary understanding about the effects of tobacco smoking, that patients in a hospital should not be permitted to smoke; and I have no cause to doubt that the respondents — who have a difficult job to do on behalf of the wider community — have throughout been acting in what they genuinely see as the best interests of their patients. I also want to make it clear that I am not endorsing the idea of a "human right to smoke". There is no "right to smoke" in a legal sense. The fundamental right in terms of this aspect of article 8 ECHR is to have your identity, how you choose to express it, and other personal, private and intimate choices, whatever they may be, *respected*, even if your choices are harmful to yourself, morally reprehensible or laughable. If you are an adult, the state cannot interfere with your choices in the private sphere except for weighty reasons to do with the protection of others and the good of the community as a whole [cf. *Mosley v News Group Newspapers Ltd* [2008] EWHC 1777 (QB) (24 July 2008); *Mosley v United Kingdom* application no 48009/08 [2011] ECHR 774 (10 May 2011)].

[6] I have decided that it would be incorrect to strike down the respondents' decision to go "comprehensive smoke-free". It is enough to declare that the decision is unlawful etc so far as it affects the petitioner. I say this for three reasons. The first reason is the main plank of the petitioner's own case: the petitioner submits that the respondents ought to have assessed his situation individually and that his individual circumstances make it unlawful to ban him from smoking in the hospital grounds. Nothing that justifies the petitioner's position necessarily applies to patients without grounds access. Secondly, the so-called "right to smoke", whatever its precise juristic character, is certainly not an absolute right: it is a right that can be waived. For all I know the vast majority of previously cigarette-smoking patients are now happy non-smokers who have waived their "right to smoke". Thirdly, I intend that nothing that I decide in this case should affect, one way or the other, the position in relation to patients who are admitted to the

State Hospital in future and who may want to smoke there. The human rights issue is about the petitioner's human rights and no one else's. As for "just satisfaction" for the breach of the petitioner's human rights, I agree with senior counsel for the respondents that appropriate satisfaction is afforded by recognising the breach without awarding damages. In fairness it should be recorded that there are many non-smoking patients in the State Hospital and that strong anti-smoking views have been expressed.

[7] A problem for the petitioner is that the smoking ban was well on the way to becoming a *fait accompli* six years ago when the respondents decided on the plan for rebuilding the State Hospital: the plan made no provision for smoking rooms. The decision was made, it appears, in the knowledge that there would be issues about the practicability of patients smoking outside. As senior counsel for the respondents said, though perhaps not intending to pun, by October 2010 when the new buildings were nearing completion, the internal smoking ban was "set in stone". This opinion comments on that decision but does not examine its lawfulness.

The petitioner's circumstances

[8] I have not been told the petitioner's age. He suffers from schizophrenia. The petitioner was charged with a number of, apparently, relatively low-grade disorder offences, breach of the peace, simple police assault, etc, on summary complaint. The sheriff made a mental health disposal which resulted in the petitioner being detained in the State Hospital. Had there been no mental health issue the petitioner might conceivably have been imprisoned. If imprisoned it is unlikely that he would have been incarcerated for more than a few months. The petitioner appeared before the sheriff in 1995 and he has now been detained for 18 years.

[9] If the petitioner were of sound mind or if his condition were of such a nature and degree that he could be treated in the community he would be able to smoke in his own home and in other places. If he were currently a patient in a medium secure unit he would be able to smoke. I was told that for part of his detention the petitioner had in fact been transferred to a medium secure unit and that, if his condition were to improve, he might be transferred there again. If the petitioner were an ambulant patient in a non-psychiatric hospital he would be able to smoke in the grounds, at least for the time being. If he were a hospice resident or a care home resident he might well be able to smoke: at least he could choose an institution that would allow him to smoke. If he were a prisoner in prison he could smoke.

[10] Persons liable to be detained in the State Hospital include patients who have entered from the criminal justice system like the petitioner, subject to orders for compulsory treatment with restriction orders, or subject to orders for compulsory treatment without restriction orders, or subject to interim

compulsion orders; and also non-criminal justice patients on orders for compulsory treatment and adults with incapacity. None of them is allowed to smoke. The petitioner is particularly aggrieved because, although he is among those patients who are allowed unsupervised grounds access during daylight hours, he is not permitted to smoke in the State Hospital grounds either. Even beyond the hospital grounds, when he is on escorted visits, the respondents' policy prevents the petitioner from smoking; and were he to visit family, he would not be permitted to smoke in the family home and visits would be conditional on no smoking by members of the household for "at least" one hour before the petitioner's visit [6/1 "Working towards a smoke-free environment: an account of the journey undertaken by The State Hospital" (The State Hospital/NHS Scotland, February 2012), 7].

Anti-smoking legislation and national policy generally

[11] Smoking in no-smoking premises is criminalised by the Smoking, Health and Social Care (Scotland) Act 2005. "No-smoking premises" are premises and classes of premises prescribed as such by regulations made in terms of section 4. The kinds of premises which may be prescribed are enclosed or substantially enclosed premises (a) to which the public has access, or (b) which are work places, or (c) which are club premises, or (d) which are used for the provision of education or health care services. Regulations prescribing no-smoking premises can also exclude parts of the premises from the definition "no-smoking premises". The list of prescribed premises is annexed as Schedule 1 to the Prohibition of Smoking in Certain Premises (Scotland) Regulations 2006. The list includes "16. Hospitals, hospices, psychiatric hospitals, psychiatric units and health care premises." The exemptions in terms of Schedule 2 include "1. Residential accommodation", "2. Designated rooms in adult care homes", "3. Adult hospices" and "4. Designated rooms in psychiatric hospitals and psychiatric units." The legislation does not prohibit smoking in hospital grounds. I was told that there are designated smoking rooms in all psychiatric hospitals and psychiatric units. Counsel also told me that smoking in outside areas is permitted at the three medium secure psychiatric units in Scotland. Staff at the State Hospital cannot smoke at the State Hospital: but as counsel for the petitioner observed, members of staff are free to leave at the end of their shifts and free to smoke in the outside world.

[12] Smoking is permissible in Scottish prisons. Rule 36 of the Prisons and Young Offenders Institutions (Scotland) (Rules) 2011/331 permits smoking in single cells, in cells for two or more prisoners which are not designated non-smoking cells and in specified open-air areas. The designation of non-smoking cells by prison authorities is governed by a direction of the Scottish Ministers, the Scottish Prison Rules (Smoking) Direction 2011. Designation criteria include the wishes of individual prisoners and reasonable

practicability. Open-air smoking areas are specified for all adult prisons. No open-air smoking areas are specified for HM Young Offenders' Institution, Polmont. (Counsel tell me that this is linked to the fact that the age threshold for purchasing tobacco products has been raised to eighteen years.)

[13] Since I heard the submissions in this case the Scottish Government has published a strategy paper, *Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland*, 27 March 2013. The ministerial foreword includes the statement: "This is not about banning tobacco in Scotland, or unfairly stigmatising those who wish to smoke." As regards prisons, the proposed action is: "The Scottish Government will work in partnership with the Scottish Prison Service and local NHS Boards to have plans in place by 2015 that set out how in-door smoke free prison facilities will be delivered." For hospitals, the proposed action is:

"All NHS Boards will implement and enforce smoke-free grounds by March 2015. Smoke-free status means the removal of any designated smoking areas in NHS Board buildings or grounds. We will work with Boards to raise awareness of the move to smoke-free hospital grounds. This action will not apply to mental health facilities."

The action proposed for mental health facilities includes a reference to the present litigation. The action is: "Taking account of the outcome of the Judicial Review of the State Hospital decision to prohibit smoking, mental health services should ensure that indoor facilities are smoke-free by 2015."

The statutory framework for the regime at the State Hospital

[14] An important issue between parties is about the statutory framework for managing the State Hospital, for detaining patients there in conditions of special security and for making decisions about the conditions of their detention including whether or not they should be allowed to smoke. Three statutes were referred to by counsel: the National Health Service (Scotland) Act 1978, the Criminal Procedure (Scotland) Act 1995 and the Mental Health (Care and Treatment) (Scotland) Act 2003. Counsel for the petitioner made reference to the Criminal Procedure (Scotland) Act 1995 only to dismiss it, saying that once a compulsion order has been made patients enter the ambit of the Mental Health (Care and Treatment) (Scotland) Act 2003. Senior counsel for the respondents did not assert that the 1995 Act has a continuing role.

[15] Mr K Campbell QC for the respondents submits that the National Health Service (Scotland) Act 1978 s. 102 confers the power to manage the State Hospital and that the smoking ban is an exercise of managerial powers under the 1978 Act. Section 102 of the 1978 Act requires the government to provide "state hospitals" for "persons subject to detention...who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities". State hospitals are under "the

control and management" of the government. The government may delegate "the management" to a special health board. The respondents are such a special health board. If senior counsel is correct, there are, except in relation, perhaps, to very specific functions in terms of the Mental Health (Care and Treatment) (Scotland) Act 2003, no statutory restrictions on the respondents' managerial decision-making powers and the only question in this connection is whether the smoking ban was and is unreasonable in the *Wednesbury* sense [*Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223].

[16] If, on the other hand, the question of the smoking ban was or ought to have been addressed by the respondents in the discharge of a function by virtue of the Mental Health (Care and Treatment) (Scotland) Act 2003, as Mr Leighton counsel for the petitioner contends, then statutory, patient-centred criteria come into play; and the primary question is about compliance with those statutory criteria. From section 1(11) of the 2003 Act we learn that "functions", as would be expected, include "powers"; and we learn as well that the non-exercise of a power also constitutes the "discharge of a function" for the purposes of the 2003 Act.

[17] The patient-centred criteria are to be found earlier in section 1 of the 2003 Act. Subsections (1) and (2) of section 1 require non-exempted persons "discharging a function by virtue of this Act in relation to a patient" to do so having regard to the matters mentioned in subsections (3) and (4) so far as relevant. The matters listed in section 1(3) are — I paraphrase — the wishes of the patient; the importance of the patient participating in the discharge of the function; the importance of providing support for the patient to enable the patient to participate; the range of options available in the patient's case; the importance of providing maximum benefit to the patient; the need to ensure that the patient is not treated less favourably than a person in a comparable situation who is not a patient; the patient's characteristics.

[18] In terms of section 1(4), after having regard to the matters just listed, the person discharging the function "shall discharge the function in the manner which appears to the person to be the manner that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances." This is the "least restrictive principle", also called the "least restrictive alternative principle" and the "principle of least restriction" [*Report on the Review of the Mental Health (Scotland) Act 1984* (SE/2001/56), otherwise the Millan Report, xv, 17, 20, 23, 53, 58, 63, 65, 71, 337, 482, 484; Council of Europe Committee of Ministers, *Recommendation concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder* Rec (2004) 10, art. 8].

[19] No submissions were made as to whether or not the respondents are "a person" for the purposes of section 1. "Persons" are not defined: but I think it fair to infer, in the absence of argument to the contrary, an intention from the terms of section 3 that hospital managers including special health boards, the respondents in this case, should be understood to be persons who "discharge functions by virtue of the

Act" for section 1 purposes. Hospital managers and special health boards are not included in the section 1(7) list of exempted persons. (Exempted persons are patients themselves, their carers, advocates, legal representatives and so on.) There are references elsewhere in the 2003 Act to the respondents as "persons": for example, section 281(5) gives a list of "persons" for the purpose of that section that includes hospital managers generally, health boards and special health boards. The code of practice published by the Scottish Ministers in exercise of their function under section 274 of the 2003 Act lists the Scottish Ministers in the example of "persons" who discharge functions under the Act; and the respondents are of course agents of the ministers in terms of the 1978 Act [*Mental Health (Care and Treatment) (Scotland) Act 2003: Code of Practice* (Scottish Executive, 2006), vol 3, chap 1, § 5].

[20] Mr Campbell QC for the respondents founds on the terms of the section 1 side note or sub-heading which refers to "Principles for discharging certain functions". He submits that the phrase "*certain functions*" signals that there are "*certain other functions*" to which the principles do not apply. If I understand senior counsel correctly, creating a smoke-free environment is not one of the "*certain functions*" while controlling patients' food parcels is (see below). Without other indicators I am not persuaded that the sub-heading to section 1 of the 2003 Act has the interpretative effect suggested. There is a perfectly good explanation for the phrase "*certain functions*"; and the explanation is that the functions in question are functions in relation to adult patients, patients like the petitioner, not functions in relation to child patients, nor organisational functions such as are assigned to the Mental Welfare Commission by part 2 of the Act, and so on. The principles for discharging functions in relation to child patients are contained in section 2 [cf. *R v Montila* [2004] 1 WLR 3141 at §§ 31—37; *WD v Glasgow City Council* 2008 SC 117 at §§ 38, 56 and 62 *per* Lord Macphail delivering the opinion of the court].

[21] Senior counsel's argument is that a distinction has to be drawn between functions relating to institutional management and functions, "*certain functions*" he would say, in relation to individual patients. He submits that the purview of section 1(3) of 2003 Act is the care, treatment, welfare and conditions of detention of individuals and functions relating to those matters. He submits that section 1(3) applies to decisions about food parcels as in the case of *L Petitioner*, because food parcels are something that comes under the heading of individual welfare. He derives his interpretation, first, from the repeated references to "*patient*", singular, and from the imperative to have regard to factors which relate to individuals such as, most obviously, "*wishes*", "*characteristics*", "*age*", "*sex*". He derives this, secondly, from the co-existence of the unrepealed (though amended) section 102 of the 1978 Act: he submits that management of the institution at a general level is a function that is exercised not by virtue of the 2003 Act but by virtue of the 1978 Act.

[22] I am inclined to reject this submission as put. The whole point of section 1(3) of the 2003 Act is to individualise decision-making about patients. Section 1 gives effect to the recommendations of the Millan Report, referred to above. The overarching Millan principle is that "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." The principle has two components. These two components have found statutory expression in sections 1(3) and 1(4) respectively: first, to ensure that "any compulsory intervention is tailored to the particular needs and circumstances of the individual"; and, secondly, to provide "any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others" [Millan Report, xv, 20—21].

[23] I also think that the 1978 Act does not obviously confer the power contended for by Mr Campbell QC. It seems to me that section 102 of the 1978 Act (as amended) does three things: it imposes a duty on the government to provide state hospitals; it requires the government to be responsible for the control and management of state hospitals; and it authorises the government to delegate the exercise of management (but not of control) to health boards and other state agents. Identifying where responsibility for management lies says nothing about the content or performance of management functions. Had the 1978 Act empowered the managers of the state hospital to detain patients, there would have been no need for separate provision for the same thing [e.g. Mental Health (Scotland) Act 1960 s. 58; Mental Health (Scotland) Act 1984 s. 60; cf. National Health Service Act 2006 s. 4].

[24] Assuming (contrary to the foregoing) that the 1978 Act confers a relevant power of management in general terms, Mr Leighton for the petitioner says that the general power must be exercised subject to the provisions of the 2003 Act. This is on the principle that specific statutory provision as to any matter necessarily supersedes prior general provision [*Richards v Richards* [1984] 1 AC 174 at 199E—200B *per* Lord Hailsham of St Marylebone LC]. All well and good in the proper context, I accept; and clearly — there is no argument about this — hospital managers as such, including specifically the respondents as the State Hospitals Board, are expressly assigned some functions by the 2003 Act. I refer for example to sections 38 and 259. Counsel for the petitioner could not however, or did not identify which section of the 2003 Act makes provision for the function which is supposed to be the basis of the smoking ban. If no such function can be identified, why should I be persuaded that the respondents were bound by the "least restrictive principle" which applies when "discharging a function... by virtue of" the 2003 Act? This point, it seems to me — though it is not a point actually advanced on this occasion — could go strongly in favour of the respondents, who maintain that they were not discharging "a function by virtue of the 2003 Act" but

merely managing the hospital in terms of the 1978 Act.

[25] If counsel for the petitioner were correct, you would expect to find some reference somewhere in the 2003 Act at the very least to detention of mentally disordered patients being a "function" of hospital managers, in this case the respondents. Having searched through all 333 sections of the 2003 Act I can find nothing that says so, certainly nothing that says so in terms. Under the Mental Health (Scotland) Act 1984 (as amended) ss. 60 and 62A, now repealed by the 2003 Act, there was clear statutory authority for hospital managers, as such and in terms, as opposed to, say, the medical superintendent, to detain patients who were the subject of hospital orders and hospital directions pronounced by the criminal courts in terms of the Criminal Procedure (Scotland) Act 1995 (as amended) ss. 58 and 59A. There is nothing equivalent in the 2003 Act (cf. Mental Health Act 1983 s.45B).

[26] Strictly, a distinction has to be drawn between "authority" to detain particular individuals and "power" to detain generally although I appreciate that in practice the distinction is not rigorously observed. I think it would be stretching the point, however, to spell the respondents' power of detention out of the current criminal law provisions. Section 57A of the Criminal Procedure (Scotland) Act 1995, as inserted by the 2003 Act, tells us that a compulsion order may authorise detention of the offender in a state hospital without actually saying, as the 1984 Act did, on whom the correlative responsibility lies for ongoing detention following admission. In similar vein, the 2003 Act almost always speaks of detention in the passive voice, so that the untutored reader could be forgiven for wondering whose function it is to actually do the detaining. 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. This is true too of functions incidental to the power to detain: for example, the existence of a duty in relation to the care and welfare of patients may be inferred from the fact that the respondents are deemed by section 259 to be incapable of providing "independent advocacy" about those matters. Possibly the closest the 2003 Act comes to telling the reader what or who is doing the detaining is section 291: section 291 makes provision for the Mental Health Tribunal to order hospital managers to *cease* detaining patients. All this leads me to think that there is a gap in the 2003 Act, or at least in the express provisions of the 2003 Act, which must be filled by necessary implication.

[27] On this not very satisfactory basis I am prepared to conclude that it was the intention of the Scottish legislature in enacting the 2003 Act that the respondents should have and exercise the power to detain patients who are committed to the State Hospital and that when the respondents detain patients and when they do anything incidental to detention, such as addressing the issue of food parcels or smoking, then, by implication, they are discharging a function by virtue of the 2003 Act. It follows that they are

bound to comply with subsections (3) and (4) of section 1 of the 2003 Act. I think that even the respondents might half agree with this on the basis that they believe their power to control food parcels in the interests, as they see it, of patient welfare is a function that exists, even without express provision to that effect, by virtue of the 2003 Act.

[28] A supplementary submission made in response by Mr Leighton for the petitioner offers another perspective. He suggests that the expression "by virtue of this Act" has a rather looser meaning than, say, the expression "in terms of a provision of this Act". The phrase "a function discharged by virtue of this Act in relation to a patient" is given its widest and, says counsel, its most effective meaning if the words "by virtue of this Act" are understood to qualify not so much the function as the whole concept "a function in relation to a patient". Since all patients are now admitted and detained "by virtue of this Act" then any function discharged "in relation to a patient" by the respondents and other non-exempted persons must necessarily be discharged "by virtue of this Act in relation to a patient".

[29] As for exempted persons, counsel argues that a narrow meaning makes the exemption of patients and patients' representatives pointless since the 2003 Act does not actually confer or impose any statutory functions on, for example, carers and patient advocates. Returning to the petitioner's situation, counsel tells me that whatever the circumstances of the petitioner's original admission to the State Hospital in 1995 he has subsequently been transferred to a medium secure unit and then, in about 2008, transferred back to and detained in the State Hospital by virtue of the 2003 Act. (I got the impression that the Mental Health Tribunal played some part in the transfer or the transfer back.)

[30] Mr Leighton gives several reasons why it ought to be the case that the respondents are bound to comply with subsections (3) and (4) of section 1 of the 2003 Act: the 2003 Act is intended to be a comprehensive code; the section 1 principles are intended to be the blueprint for all interventions relating to mentally disordered persons; if it were permissible to pray in aid other sources the power to deal with such persons, whether common law or statutory, it would be all too easy to circumvent the section 1 principles; and it would be productive of anomalies if the section 1 principles were confined in their application to individual interventions and were not to apply to the treatment of groups of patients. These are possibly not reasons to arrive at the conclusion to which I am drawn: but they offer some comfort that the conclusion is the right one.

[31] Counsel for the petitioner finds a parallel in the provisions of the Adults with Incapacity (Scotland) Act 2009. The 2009 Act sets out the general principles for any intervention in the affairs of an incapable adult "under or in pursuance of this Act". In terms of section 1(2) there must be no intervention unless the person responsible for the intervention is satisfied that the intervention will benefit the adult and that

such benefit cannot reasonably be achieved without intervention. Section 1(3) provides that any necessary intervention "shall be the least restrictive option in relation to the freedom of the adult, consistent with the purpose of the intervention".

[32] When considering the relationship between the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Criminal Procedure (Scotland) Act 1995 I could not help noticing a conundrum — this is not a point raised by counsel — residing in the phrase "discharging a function by virtue of this act" for the reason that "this act", i.e. the 2003 Act, enacts a raft of provisions to be inserted into the 1995 Act about the criminal justice routes to detention and the functions to be discharged in that connection [Mental Health (Care and Treatment) (Scotland) Act 2003 ss. 130—133, 331, 333, sched 4, etc]. Are these criminal justice functions, now to be found in the 1995 Act (as amended), subject to 2003 Act section 1 principles? The same question can be asked about functions discharged by virtue of subordinate legislation made under the authority of the 2003 Act.

[33] The subordinate measures of interest in the present context are the Mental Health (Safety and Security) (Scotland) Regulations 2005 (as amended) made in terms of section 286 of the 2003 Act. Regulation 4(d), read with regulations 2 and 5, provides — I paraphrase — that the respondents may take measures to prohibit State Hospital patients from having in their possession articles "that 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" and to authorise the removal from patients of prohibited articles. The hypothesis underlying the smoking ban is of course that smoking does pose a health risk; and, as will be seen below, the respondents purportedly extended the ban to outside areas and made it apply to all patients for reasons of "security and good order". There was clearly some discussion at the time with the head of security about making tobacco-related products "a prohibited item". The respondents did, in their own words, "place a restriction on the amount of tobacco that could be purchased" from the hospital shop. They then "prohibited all tobacco related products" and they declared electronic cigarettes to be "a prohibited item": but there is no indication that the statutory route was followed [6/1, "Working towards a smoke-free environment: an account of the journey undertaken by The State Hospital" (The State Hospital/NHS Scotland, February 2012), 12, 14; 7/17(47), minute of Smoking Cessation Task Force meeting 8 September 2011, 2; 7/17(80), 4, email exchange between smoking cessation adviser and head of security 15 September 2011; also 7/17(80), 5, Information Notice for Carers].

[34] What I find a bit of a mystery is why, given the existence of a seemingly clear power to treat tobacco products as contraband for health reasons, the respondents do not purport to have acted under the 2005 Regulations. Could it be that smoking, as previously managed in the State Hospital, is not after all a

"significant" health risk? Could it be that the Millan principles, which are independently enshrined in the regulations, might have thwarted the blanket smoking ban? Regulation 8(2) provides that restrictions placed on the possession and use of articles must have the minimum impact on the freedom of patients compatible with addressing the risks in question; and regulation 5 provides that the rationale for applying restrictions has to be documented for each individual patient by that patient's responsible medical officer.

[35] My instinctive reaction is that public authorities cannot side-step the obligations attached to powers conferred by legislation by acting or purporting to act on a discretionary basis outside the legislation. Since, however, counsel did not address me on the significance of the regulations, I cannot make too much of them. What I can safely take from the regulations, I believe, is a hint that the "least restrictive" philosophy, whether by virtue of section 1 of the principal Act or otherwise, is intended to shape all aspects of the regime to which detained patients can properly be compelled to submit.

[36] One argument that might have been advanced for the petitioner — but was not, although the relevant material has been put before me — is that whether or not the respondents were statutorily bound to act in accordance with 2003 Act section 1 principles, they believed themselves to be discharging a function or functions by virtue of the 2003 Act and intended — at least from a certain date — to act in accordance with those principles. After the event, in February 2012, the respondents produced a paper about the implementation of the comprehensive smoking ban, "Working towards a smoke-free environment". I emphasise the word "environment" in the title. The paper states, by way of background: "With the Mental Health (Care and Treatment) (Scotland) Act 2003 came statutory requirements to ensure patients were treated in accommodation appropriate to their needs and in an environment that supported rehabilitation" [6/1, "Working towards a smoke-free environment: an account of the journey undertaken by The State Hospital" (The State Hospital/NHS Scotland, February 2012), 1].

[37] "Rehabilitation" does come within the 2003 Act definition of "medical treatment": but there is actually no mention whatsoever of "environment"; and there is no relevant reference to "accommodation" [cf. National Health Service (Scotland) Act 1978 s. 36]. However, as noted above, delivering care in "the least restrictive manner and *environment*" is part of the Millan principle, second component [my emphasis]; and the idea has found its way into the code of practice, expressed in different ways as "the least restrictive environment" and as "the least restrictive, safest and most therapeutic environment possible". The respondents may also have been influenced by the fact that the mission of the health authority responsible for Rampton high security prison in England was reportedly "to deliver health care to its patients... in a secure and clinically appropriate environment" [Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice, vol 3, compulsory powers in relation to mentally disordered

offenders, § 71; vol 2, civil compulsory powers, § 52; *R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 at § 62 *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ]. [38] Of course the respondents may have thought, not without reason, that such "statutory requirements" though not actually expressed in the 2003 Act are clearly implied. In any event, the comprehensive smoke-free initiative does seem to have been badged by the respondents as a legitimate discharge of their functions by virtue of the 2003 Act. The initiative was substantially a medical one; and the extent of medical input may argue against the idea that what was involved was simply an institutional management function. The supporting paper presented to the board meeting of 28 October 2010, at which the respondents unanimously agreed to work towards the comprehensive ban, was written by the medical director Dr (now Professor) Lindsay Thomson FRCPsych (co-author and editor, *Mental Health and Scots Law in Practice*); and the smoke-free task force was led by Dr Fergus Douds MRCPsych, the joint associate medical director. It was planned for every smoking patient to have an individual care plan to cater for his individual (smoking cessation) needs [7/8, minute of board meeting, 28 October 2010; 7/9, "Smoking", report by medical director; 7/11, minute of board meeting, 3 January 2011; 7/17(74), WTSFE Patient Forum, 14 July 2011, 2].

[39] As the task force went about its work, there is evidence that, whatever they thought at the outset, the respondents came to believe that they were under a duty to comply with the section 1 principles whenever they exercise a function, any function apparently, in relation to adult patients. I take this from the terms of the respondents' submissions as recorded by Lady Dorrian in the case of *L v Board of State Hospital* 2011 SLT 233. Lady Dorrian's case was a challenge to the respondents' attempt to prevent patients from requisitioning food from outside the hospital. The respondents conceded that they were under an obligation to comply with section 1 principles. The main determining issue was whether the respondents had adequately complied with the section 1(3) obligation to have regard to patients' wishes. Lady Dorrian held that the respondents "had failed to consult as required under the legislation", meaning as required by the 2003 Act s. 1(3). Lady Dorrian did not have to consider in detail the question — which looms large in the present case — of compliance with section 1(4): but "the absence of reasons for selecting the most restrictive opinion [*option?*] in each case" was part of the ground for setting aside the respondents' food parcels ban [*L v Board of State Hospital* 2011 SLT 233 at §§ 1—5, 24, 26 at 239B].

[40] On 1 February 2011 a patient's legal aid application relating to judicial review of the decision to go smoke free on 16 May 2011 was intimated to the NHS Scotland Central Legal Office (see below). One of the grounds of action was alleged non-compliance by the respondents with section 1 of the 2003 Act. Lady Dorrian's opinion was issued the next day, on 2 February 2011. At the respondents' board meeting of

17 February, the opinion was considered as agenda item 4. In the copy minute of the meeting produced in the present proceedings, the whole of item 4, except the heading, has been redacted. Item 5 on the agenda at the same meeting was "Achieving a smoke-free Environment at the State Hospital". The minute records that the respondents were advised that "Lady Dorrian's judgement in relation to the restrictions placed on food items at The State Hospital, reinforced the importance of good communication and proper consultation with all stakeholders when major changes are proposed". The outcome, as recorded, was that the respondents' previous, unanimous decision to enforce a total smoking ban from 16 May 2011 was rescinded; and that consultation with all "stakeholders" would take place. On 10 March 2011 there was a meeting of the Patient Partnership Group [PPG] to hear an update from the Smoking Cessation Task Force on the plans for consultation. Ten patients were present. In a reference to *L Petitioner*, one patient said that the only reason the hospital was consulting was because the foodstuffs ban had been overturned by the court. The Smoking Cessation Task Force leader was recorded as replying "that the hospital had learned from the previous situation". The task force leader's report for the board meeting of 23 June 2011 effectively recorded that the change of direction was because of the terms of Lady Dorrian's legal judgment. During the hearing of the present case I noted senior counsel for the respondents as telling me that "as a result of *L Petitioner* the [smoking ban] consultation process took place" [7/8, minute of board meeting 28 October 2011, 2; 7/12, minute of board meeting 17 February 2011, 2; 7/17(11), note of PPG meeting 10 March 2011, 3; 7/20 report by joint associate medical director June 2011, 1 "Background"; also 7/17(5), minute of Carers Services Group meeting February 2011, 1—3].

[41] To sum up, I have come to the view that when the respondents addressed the question of banning smoking they were exercising a function by virtue of the Mental Health (Care and Treatment) (Scotland) Act 2003 and were bound to comply with the decision-making principles set out in section 1 of the 2003 Act. In any event the respondents, even if they were not bound to do so, chose to proceed in accordance with section 1 principles as they understood them. This was not an unjustified fetter on the exercise of their judgement: it was a reasonable, responsible and lawful thing for them to do. The question is whether the respondents succeeded in complying with section 1 principles.

Convention rights case law

[42] Discussion of the case law by counsel focused on *R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 and *L v Board of State Hospital* 2011 SLT 233, referred to above. In *R(N)* the Court of Appeal of England & Wales, by a majority, dismissed an appeal against a decision of the Divisional Court refusing applications for judicial review of the smoking ban at Rampton Hospital, one

of three high security mental hospitals in England & Wales. Mr Leighton, counsel for the petitioner sought to distinguish the decision of the majority in *R (N)*; and Mr Campbell QC for the respondents sought to distinguish the decision of Lady Dorrian in *L Petitioner*.

[43] I can deal with *L Petitioner* shortly. That decision indisputably proceeded on the basis of a concession that section 1 of the 2003 Act applied. Senior counsel for the respondents, who also appeared for the respondents in *L Petitioner*, told me that I could take it that the concession was made on instructions. He submits that the concession was properly made on the view that the issue was about what patients could eat; that what a patient eats is the most basic aspect of individual welfare; and that the issue of a smoke-free environment is different. It is true that, in relation to the article 8 ECHR question, Lady Dorrian treated "the freedom to receive food parcels from visitors and to make purchases from an external source" as an important aspect of personal autonomy for patients whose area of choice was otherwise greatly restricted. In saying this Lady Dorrian distanced herself from the view of the majority in *R (N)*. My view is, agreeing with senior counsel, that the concession in *L Petitioner* as to the application of section 1 of the 2003 Act was properly made and, disagreeing with senior counsel, that, as a matter of statutory construction, section 1 applies as much to the smoking ban as it does to the food parcels ban [*L v Board of State Hospital* 2011 SLT 233 at §§ 5, 25, 26; *R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 at §§ 42, 44, 46 *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ].

[44] *R (N)* is authority for the propositions (1) that the statutory ban on smoking within psychiatric hospital buildings in England & Wales is lawful, not contrary to articles 8 and 14 ECHR, and not irrational; and (2) that the decision of Nottinghamshire Health Care NHS Trust to ban smoking internally at Rampton high security psychiatric hospital, introduced on 1 April 2007, was lawful and not contrary to articles 8 and 14 ECHR. Clearly, as counsel for the petitioner submitted, *R (N)* can be distinguished on the basis that the legislation is different, both the smoking legislation and the mental health legislation. Counsel told me that there was nothing like section 1 of the Scottish 2003 Act in the mental health statutes for England & Wales. (Counsel's submission has to be qualified by reference to the statement of principles now required to be inserted into the code of practice for England & Wales by virtue of section 118(2A)—(2D) of the Mental Health Act 1983 as amended by the Mental Health Act 2007 ss. 8 and 56 effective from 3 November 2008.) In any event nothing in the decision of the Court of Appeal refers to section 1-type principles

[45] The English legislation which totally banned internal smoking came into force on 1 July 2007. The legislation granted only a 12-month exemption, until 1 July 2008, for "mental health units" and after that

the ban became total [Health Act 2006 ss. 1—3, 79; Smoke-Free (Exemption & Vehicles) Regulations 2007 regs. 5 and 10]. Indeed, an argument that, ironically, found favour with Keene LJ dissenting was that "neither the Scottish Executive nor the Welsh Assembly have found it necessary to impose such a total ban on smoking in the interiors of mental health hospitals and units" [*R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 at § 107 *per* Keene LJ]. The issue in *R (N)* was about the lawfulness of the internal smoking ban at Rampton: the Rampton applicants did not challenge the ban — imposed for security reasons — on smoking in the hospital grounds. These points of distinction on the facts were also drawn to my attention by counsel for the petitioner and I accept them [*R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 at § 67 *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ].

[46] I also accept that, as senior counsel for the respondents submitted, the article 8 ECHR discussion in *R (N)* does have relevance to the present case: but I do not agree that the outcome of the discussion as expressed by the majority is persuasive. In *R (N)* the patients contended that the hospital was to be regarded as their "home" for the purpose of article 8 ECHR (right to respect for private life and home); that smoking is an activity protected by the article 8 guarantee; that the total ban on smoking indoors was unnecessary and disproportionate in terms of article 8 ECHR and therefore unlawful.

[47] The Court of Appeal was divided on the question of whether the Rampton smoking ban engaged article 8(1) ECHR. The majority held that whether or not an activity attracts article 8(1) ECHR protection is a function of the nature of the place in which the activity is carried out in combination with the importance of the activity to the "physical and moral integrity" of the individual; and that smoking by patients in a high security mental hospital is not protected. For the majority, the question of the proportionality of the Rampton ban did not therefore arise for consideration in terms of article 8(2) ECHR. Had the question arisen, the majority, addressing the question hypothetically, would have been satisfied that the smoking ban was necessary and proportionate for the legitimate aim of protecting the health of the Rampton patients; and that "the 2007 Regulations were enacted following an intensive consultation exercise and intense parliamentary scrutiny through the affirmative parliamentary procedure and scrutiny by the Joint Committee on Statutory Instruments" and should be respected by the courts [*R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 at §§ 30—54, 71, 74, 75, 88 *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ].

[48] Lord Justice Keene dissented on the issue of whether article 8(1) ECHR was engaged and on the question of the proportionality of the smoking ban in terms of article 8(2). On the question of engagement, his lordship quoted the Secretary of State during the third reading of the Health Bill, when she justified

taking the power to grant exemptions for "people's own homes and places that are, in effect, someone's home, at least temporarily... not only because we believe it is right in principle, but to fulfil our obligations under the Human Rights Act 1998 on respect for private life." The Secretary of State's list of "temporary homes" included "mental health hospitals". His lordship continued:

"I note that the Trust accepts that Rampton is the appellants' home. It is, as the majority says, not their home of choice, any more than would be a prison, but that does not take it outside the ambit of art. 8(1). There are, after all, innumerable cases where art. 8 has been applied to those in prison, and a secure mental hospital where a convicted person is held for, in many cases, a considerable number of years is just as much a home as is a prison for these purposes."

On the evidence in *R (N)* the Secretary of State was aware "that the absence of any exemption for mental health units beyond July 1, 2008 would mean that some patients would face a complete ban on smoking because they would not be allowed to go outside and so would be confined to enclosed areas."

[49] It was against this outcome that Keene LJ assessed the proportionality of the 2007 Regulations in terms of article 8(2) ECHR. He said that there was nothing to show that Parliament appreciated that the expiry of the time-limited indoor-smoking exemption would eventuate in a complete ban on smoking in secure psychiatric hospitals; and that this outcome had not received democratic endorsement. Differing from the majority, Keene LJ emphasised the public health objective "of protecting people from other people's smoke". He concluded that regulation 10 combined with the unavoidable prohibition on smoking outdoors was more than was necessary to accomplish the stated public health objective and was therefore disproportionate. His lordship found that the hospital trust was not in breach of its article 8 ECHR obligation for the reason that it was bound to implement the statutory indoor smoking ban and because the trust's reasons for not permitting smoking outdoors were convincing [*R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 at §§ 101—108, 111 *per* Keene LJ; appendix, A §§ 19, 20].

[50] Like Lady Dorrian in *L Petitioner* I have reservations about the approach of the majority in *R (N)*; and I respectfully agree with her ladyship's observation that the issue in this sort of case is likely to be not whether article 8(1) ECHR is engaged but whether interference can be justified as necessary and proportionate in terms of article 8(2) ECHR. As her ladyship said: "It seems to me that the limitations do arise from the nature of the place, but only because they are justified in terms of art. 8(2)" [*L v Board of State Hospital* 2011 SLT 233 at 25E].

[51] I would, with respect, identify additional difficulties in the reasoning of the majority in relation to proportionality. The majority founded on a *dictum* of Lord Bingham in *Kay* for the proposition that, within the bounds set by statute, public authorities have a right to manage and control their land and buildings as

they see fit: but *Kay* subsequently went to Strasbourg where the court decided that the freedom of public authority landlords is also restricted by the article 8 ECHR rights of their tenants [*R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 at § 61 *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ; *Kay v Lambeth Borough Council* [2006] 2 AC 465 at § 36 *per* Lord Bingham of Cornhill; *Kay v United Kingdom* (2012) 54 EHRR 30].

[52] I have difficulty too with the proposition that the Rampton smoking ban was justifiable by reference to the hospital trust's common law duty to prevent their patients from "committing suicide or self-harming". Of course it may be that there is such a duty under the common law of England & Wales: but if hospital managers really did have a duty to stop patients smoking for their own good, I have to ask whether there could have been any possible justification for the legislature to grant even a time-limited exemption for psychiatric hospitals. Besides, as the Strasbourg court has observed in the case of *Pretty*: "... the ability to conduct one's life in a manner of one's own choosing may also include the opportunity to pursue activities perceived to be of a physically or morally harmful or dangerous nature for the individual concerned". Article 8(2) ECHR authorises interventions which are "necessary in a democratic society... for the protection of health or morals": it is not a warrant for lifestyle fascism [*R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 at §§ 62, 65, 70, 72 *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ; *Pretty v United Kingdom* (2002) 35 EHRR 1 at § 62].

[53] The present case is to be distinguished from *R (N)*, the majority position at any rate, in that the respondents in the present case, correctly if I may say so, do not claim that they were and are obliged as a matter of law and for his own good to stop the petitioner smoking: their voluntary smoking cessation programme and consultation exercises on the proposed smoking ban must have been premised on the understanding that patients, though mentally disordered, were able to make rational choices for themselves about smoking — or choices which were at least as rational as the smoking choices made by the general population. The duty of care referred to by the respondents in their *pro forma* repudiation letter to the petitioner's solicitors dated 9 May 2012 is "a duty of care to protect our non-smoking patients from passive smoking, as well as all of our staff and other visitors". No one would quarrel with that [7/2].

[54] A point about the working of article 8 ECHR that did not arise in *R (N)* but which does arise in the present case is the point about the legal basis for any intervention. Where article 8(1) ECHR is engaged, any interference has to be both "in accordance with law" and proportionate. If the respondents have not complied with section 1 principles when they ought to have done, then their intervention is not "in accordance with law" for the purpose of article 8(2) ECHR, assuming article 8(1) ECHR is engaged. (I should also mention that if the respondents have wrongly failed to proceed in terms of the Mental Health

(Safety and Security) (Scotland) Regulations 2005 when they should have taken that route, the same would apply.)

[55] If questionable elements of the majority decision are stripped out from *R (N)* then the minority view probably has more relevance to the present dispute. In any event, allowing for the differences in the Scottish situation and the different profile of the present dispute, I am unable to find the majority opinion persuasive. Simply confining my attention to the merits of the respective arguments in the present case, I take the view that article 8(1) ECHR is engaged so that the question is whether the respondents have shown that their interference with the petitioner's smoking habit was and is lawful, necessary and proportionate in terms of article 8(2) ECHR.

[56] In *R (N)* there was also a division of opinion on the question whether the smoking ban was a discriminatory intervention contrary to article 14 ECHR (enjoyment of Convention rights without discrimination), that is whether there had been a violation of article 14 ECHR taken together with article 8 ECHR. The majority found that, since smoking by patients at Rampton was not protected by article 8 ECHR, there was no breach of article 14 ECHR. Had the question arisen the majority would have found many reasons to be satisfied that the different treatment of high security patients on the one hand and, on the other hand, prisoners, care home residents, terminal-care hospice residents, non-mental health patients and so on was justified. Several of the reasons are peculiar to the situation in England & Wales.

[57] I reject the submission for the respondents in the present case that the relevant comparator for article 14 ECHR purposes is a patient in a high security psychiatric hospital in England & Wales, either Ashworth, Broadmoor or Rampton. The Scottish authorities are not responsible for the treatment of patients in England & Wales [cf. *R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 at § 28 *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ]. (In any event for 2003 Act s. 1(3) purposes, the comparator must be someone who is "not a patient".) Counsel for the petitioner submits that the comparison must be with prisoners in Scotland. This makes sense at least to the extent that the Scottish Ministers are, collectively, the public authority responsible for the treatment of patients at the State Hospital and for the treatment of prisoners in Scottish prisons.

[58] If there is discrimination, then, it is by the Scottish Ministers. It is the Scottish Ministers who make the Prison Rules, in particular the Prisons and Young Offenders Institutions (Scotland) Rules 2011, in exercise of powers conferred by the Prisons (Scotland) Act 1989 and other legislation. The Scottish Ministers also make the Prison Directions including the Scottish Prison Rules (Smoking) Direction 2011 in terms of powers conferred by the Prison Rules 2011, etc. A possible flaw in the argument is that the petition is not actually directed against the Scottish Ministers but solely against the State Hospitals Board

as respondents; and these respondents have no responsibility for the Scottish Prison Service. It is not the respondents who are treating mental health detainees and penal detainees differently. The point is not however taken at this time by the respondents and I am proceeding on the assumption that the respondents are content to be seen as a surrogate for the Scottish Ministers.

[59] I take the view that relevant comparators generally are the classes of persons in whose favour the Scottish exemption provisions are conceived. Two of those classes, mental health detainees at the State Hospital and penal detainees, share defining characteristics, namely that they are, or are likely to have been, detained under compulsion by the criminal courts, and that they are in enforced residence, unable to choose other accommodation if the conditions of detention are uncongenial, though subject to article 5 ECHR guarantees. In the year 2011—2012, four out of five admissions to the State Hospital were directly from the criminal courts or by transfer from prisons. As Mr Leighton for the petitioner pointed out, mental illness is notoriously prevalent in the prison population. The comparison is susceptible of greater refinement by making it with long-term prisoners. I say "long-term prisoners" because the average period of detention in the State Hospital is eight years and the average age of patients is 42 years. In the case of *R (N)* the majority was prepared to accept, for the sake of argument, that the relevant comparison was with prisoners in England & Wales; Keene LJ made the same comparison; and this was the article 14 ECHR argument supported by the Equality and Human Rights Commission ["Patients 2011/12" in *Care and Treatment* (The State Hospital/NHS Scotland) at <http://www.tsh.scot.nhs.uk/>; 6/2, *Psychiatric Morbidity among Prisoners: Summary Report* (ONS/ Department of Health, 2001); 6/3, *Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons* (HMIP/ Scottish Government, 2008); *R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 at § 59 *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ, at § 109 *per* Keene LJ]

[60] I am satisfied that there is a difference in the treatment of high security patients as compared with long-term prisoners in Scotland; and that, as counsel for the petitioner submitted under reference to the Strasbourg case law and to *R (N)*, that the difference is on the ground of "other status" within the meaning of article 14 ECHR. The argument is rather stronger than it was at the time the similar argument was before the Court of Appeal in *R (N)*. At the time of the hearing and decision in *R (N)* the case of *Clift* had been decided by the House of Lords against the claimant: since the decision in *R(N)* the case of *Clift* has been decided by the Strasbourg court, unanimously, in the claimant's favour [*Engel v Netherlands* (1979-80) 1 EHRR 647 at § 72; *DH v Czech Republic* (2008) 47 EHRR 3 at § 175; *Glor v Switzerland* application no 13444/04, 30 April 2009 at § 80; *Clift v United Kingdom* application no 7205/07, 22 November 2010 at §§ 55—63; *R (N) v Secretary of State for Health and Nottinghamshire Health Care NHS Trust* [2009] HRLR 31, 927 at

§§ 55—59 *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ]. The question therefore is whether there is a reasonable and objective justification for the difference in treatment.

[61] The petitioner also has a case based on violation of the first protocol, article 1 ECHR (right not to be deprived of property)) as a stand-alone claim and in combination with article 14 ECHR (enjoyment of Convention rights without discrimination). The petitioner's complaint is not about the confiscation of his cigarettes, not that he cannot retain, use and enjoy cigarettes which he actually owns and possesses: his complaint is that he cannot acquire cigarettes to smoke. In the absence of any authority to support the petitioner's interpretation I hold this branch of the case to be irrelevant. In any event it seems to me to add little or nothing to the claim.

The decision-making process and reasons for the decision

[62] Senior counsel for the respondents, Mr K Campbell QC, presented a suite of documents which, he said, recorded the decision-making process that culminated in the comprehensive smoking ban at the State Hospital. The context for the implementation of the comprehensive smoke-free policy at the State Hospital was the move from the old hospital buildings to the new-build hospital on the same site at Carstairs. The new hospital had in fact been built without smoking rooms. This had been the plan from possibly as early as 2005.

[63] Mr Campbell QC told me that the Smoking, Health and Social Care (Scotland) Act 2005, Part 1, gave expression to aspects of a broader public policy to encourage smoke free facilities. Senior counsel referred to the guidance document *Smoke Free Scotland*. The guidance was aimed at among others persons in the NHS concerned with the development of smoking policies. The purpose was two-fold: first, to enable such persons to comply with the smoke-free provisions of the 2005 Act, effective from 26 March 2006, with specific advice for persons in control of exempted premises; and, secondly, "to advise on an approach to tobacco which will maximise the benefits of becoming smoke free". I was pointed to the executive summary where I learned that persons working in the NHS and others "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" [7/21, *Smoke Free Scotland: Guidance on smoking policies for the NHS, local authorities and care service providers* (December 2005), iii, 5].

[64] The ownership of this document is not absolutely clear but it seems to be a partnership between the Scottish Executive and ASH [Action on Smoking and Health]. ASH is a public health charity whose objects are, I understand, (1) to preserve and protect the health of the public against the harmful effects of cigarette or other tobacco products and (2) to advance the education of the public about the effects of

cigarette and other tobacco and nicotine products. The foreword to the document runs in the names of the Scottish Executive minister for health and community care and the Convention of Scottish Local Authorities [COSLA] spokesperson for social work and health improvement. The author was someone called John Griffiths.

[65] Looking further into the document I see that the text tends to confirm the suggestion made by senior counsel that the exemptions permitted by the legislation for adult care homes, residential psychiatric facilities and adult hospices are related to the fact that such places are, for the duration of stay, considered to be the homes of the residents and patients. (Domestic premises are not covered by the legislation.) In relation to care homes, the guidance explains: "The exemption for designated rooms in these premises was made in recognition that they are residential establishments." The guidance continues: "If it is not possible to provide a designated room for smoking in line with the legislation then the building must be smoke-free." The same principles are said to apply to residential psychiatric hospitals. The document also tells me that as at the date of publication the Scottish Executive was developing "a specific national framework for mental health services... to augment the advice contained in this guidance". I note that "for humanitarian reasons" the legislation was not extended to adult hospices. There is a relevant passage in chapter 5, "Overcoming likely challenges and obstacles":

"It is important to be clear with people that the legislation and associated workplace restrictions on smoking do not call into question an adult's right to buy and smoke tobacco... The key issue is not whether a person smokes, but when and where they do so and the impact this has on other people."

This, to my mind, makes crystal clear the public health, or public protection thrust of the policy [7/21, *Smoke Free Scotland: Guidance on smoking policies for the NHS, local authorities and care service providers* (December 2005), 19, 20, 26].

[66] Senior counsel submitted that there was in existence a clear public policy directed to the achievement of a smoke free environment and that the policy was part of the context in which the respondents, as a health board, made the decision to move to a smoke free hospital. The medical director of the health board presented a report on smoking to the board's meeting of 28 October 2010. The introduction made four points: first, whereas the 2005 Act included an exemption for "designated rooms" in psychiatric hospitals, the overwhelming majority of other workplaces, including hospitals, had successfully implemented the smoke-free legislation; secondly, the Scottish Government had held a consultation process "Towards a smoke-free future" (March 2010) which showed that a majority of respondents, especially individual respondents, favoured the retention of the "designated rooms" exemption for psychiatric hospitals and that it was a common view that there should be greater accommodation of the

smoking preferences for long-stay and elderly patients; thirdly, smoke-free policies had been implemented by the removal of smoking rooms at mental health facilities in three locations, Southern General Hospital, Glasgow, Leverndale Hospital, Glasgow, and Dykebar Hospital, Paisley; fourthly, the Scottish Government planned to produce guidance by the end of 2010 on how best to achieve a smoke-free mental health service [7/9, report by medical director, 28 October 2010, 1].

[67] The respondents have produced what I take to be the resulting guidance, namely *Smoke-free mental health services in Scotland: implementation guidance*. The foreword by the Minister for Public Health and Sport said:

"... Allowing smoking in designated rooms in residential mental health services, when it is completely banned in all other NHS settings, perpetuates inequalities. Patients and staff who work in mental health settings should have the same opportunities to enjoy the benefits of a smoke-free environment as the rest of NHS Scotland. . . the guidance will support and encourage a move towards smoke-free settings at a pace which suits the services' particular needs and circumstances. Our extensive consultation . . . suggests that this approach is preferable to the statutory smoking bans in residential psychiatric premises which have been in place elsewhere in the UK over the last couple of years."

I have taken the liberty of looking at the results of the consultation referred to in the ministerial forward for an understanding of why statutory smoking bans were ruled out: only 35% of respondents favoured removing the statutory exemption for psychiatric hospitals; and it was commonly thought that long-stay and elderly patients should have their smoking preferences accommodated where possible. This is in effect what the medical director told the respondents on 28 October 2010 [L Nicholson, *Achieving Smoke-free Mental Health Services in Scotland: Analysis of Consultation Responses* (NHS Scotland, 2010), summary, v].

[68] The 2011 guidance expressed the expectation that all those responsible for implementing smoke-free policies in mental health settings would share certain "core principles". One of the core principles is that smoke-free policies are not moral statements: "they restrict where and when people can smoke rather than restricting the choice of whether to smoke or not." The guidance also advised that "common myths should be debunked robustly". The myths to be debunked included, under reference to the Human Rights Act 1988 [sic] and decisions of courts in the United States, the myth "that smoke-free policies breach smokers' human rights" and, under reference to the decision of the Court of Appeal in *R(N)*, the myth that "a mental health hospital constitutes the in-patient's 'home'" [7/22, *Smoke-free mental health services in Scotland: implementation guidance* (NHS Scotland, February 2011), i, 4, 6, 35, 36].

[69] Since internal smoking areas had been designed out of the new-build hospital scheduled for occupation in late 2011, the issue for decision by the respondents on 28 October 2010 was restricted to whether smoking should continue to be allowed in the hospital grounds and in ward gardens or whether

there should be a complete ban on smoking. In the event that the board were to opt for a complete ban, consideration would require to be given as to the timing of the complete ban, whether it should be in May 2011, prior to the move to the new "hubs and clusters", or whether it should be from October/November 2011, following the opening of the new hubs and clusters [7/9, report by medical director, 1 and 8].

[70] The largest section of the medical director's ten-page report is the six-page literature review backed by two pages of references. The topics covered in the literature review were: the effects of smoking cessation on mental health; the effects of smoking cessation on anti-psychotic medication; the effects of smoking cessation on physical health; the effects of smoking cessation on weight; the effects of smoking cessation on violence and aggression in mental health settings; smoking cessation interventions; staff and patient attitudes to smoking; national guidelines; the limitations of existing research and research opportunities arising from a ban at the State Hospital; non-health benefits of smoking cessation; and the Rampton experience. The minute of the board meeting of 28 October 2010 suggests that the medical director summarised the literature review as contained within her report [7/8, minute of board meeting, 28 October 2010; 7/9, report by medical director, 2—7, 9 and 10].

[71] The introduction to the literature review section included the following piece of scene-setting:

"Harris et al (2007) reported various studies which show the highest rates of tobacco addition in people with major mental illness, especially schizophrenia. It is also reported widely that patients with serious mental disorder are heavier and more efficient smokers. The consequence of this higher smoking rate is a substantially greater risk of premature death from smoking related diseases than is seen in the general population — people with schizophrenia were found to have a 10-fold greater risk of death from respiratory disease compared with the general population. The high levels of smoking in people with mental illness, combined with the fact that one in two smokers dies prematurely, mean that the death toll from smoking far outweighs other risks, such as the 10% lifetime risk of suicide."

The conclusion of the report was:

"Smoke-free policies have succeeded in mental health settings in the UK, United States, Australia and Canada; no increases have been seen in violence and aggression, restraint, seclusion, or use of 'as needed' medication in the vast majority of sites that have imposed total bans on smoking."

I deduce that the conclusions in relation to overseas experience were drawn from the studies footnoted in the sub-section headed "The Effects of Smoking Cessation on Violence and Aggression in Mental Health Settings".

[72] The United Kingdom data on total bans in residential psychiatric facilities appears to be summarised in the sub-section headed "The Rampton Experience". No literature is referenced and the summary seems to have been drawn mostly from court reports of the *R (N)* proceedings in the Divisional Court and the

Court of Appeal (see above). In March 2007 Nottingham NHS Healthcare Trust imposed a total smoking ban on all residential mental health units within the trust's jurisdiction including Rampton high-security psychiatric hospital. The trust policy allowed case-by-case exceptions for individual patients. Exceptions were not however allowed at Rampton because of, it was said, "the logistical difficulties of a high-security hospital and the challenge of escorting patients to a secure place to smoke" [7/9, report by medical director, 7].

[73] In late 2009 it became apparent that the Rampton case would not be taken to the Supreme Court because of the refusal of legal aid. By the date of the medical director's report to the State Hospital board in October 2010, total smoking bans had also been introduced at the other two high-security units in England & Wales, namely Broadmoor and Ashworth. The medical director reported to the board that it was likely that there would be a legal challenge (in Scotland) if the board decided on a complete ban at the State Hospital. The medical director also advised that there were gaps in the research data and that imposing a smoking ban at the State Hospital would provide an opportunity to contribute to existing research in a number of ways [7/9, report by medical director, 6, 7 and 8].

[74] The minute of that board meeting records the following decision on agenda item 2, "Policy on Smoking in the State Hospital":

"Members discussed a wide range of issues of the report and the options set out. It was agreed that the status quo was not an option as there would be no internal smoking areas within the new Hospital, therefore consideration was given to a partial smoking ban — smoking permitted within the Grounds; or a total ban — no smoking permitted in any area (internal or external) of The State Hospital.

The Board unanimously agreed that the Hospital should work towards a complete smoking ban with effect from May 2011. The specific date would be decided and communicated in due course. Members also agreed on the importance of working together with patients, carers and staff towards achieving this goal. The Board would be open to consideration of any evidence or information they may have failed to consider."

The board agreed that the chief executive should appoint a smoking cessation "task force" to take the lead in implementation [7/8, minute of board meeting, 28 October 2010]. The plan for early implementation of a total ban was then thrown off course by the judgment of Lady Dorrian in the case of *L v Board of State Hospital* handed down on 2 February 2011.

[75] Lady Dorrian's judgment quashed a decision by the board to ban patients from receiving food parcels from visitors or requisitioning food from outside sources. The reasons for quashing the board decision included lack of consultation with patients. The respondents discussed the judgment as agenda item 4 at the board meeting of 7 February 2011. Agenda item 5 on 7 February 2011 was "Achieving a smoke-free

Environment at the State Hospital". This was the title of a report by the associate medical director which was tabled for discussion. The minute records:

"... At their meeting on 28 October 2010, the Board had unanimously agreed that the Hospital should work towards a smoke free environment and the date of implementation was subsequently agreed as Monday 16 May 2011. [*The chairperson*] advised that Lady Dorrian's judgement... reinforced the importance of good communication and proper consultation with all stakeholders when major changes were proposed. In the circumstances, Members noted that there may be a need to amend the decision taken in October 2010 around smoking in The State Hospital..."

[...]

Members agreed that the Hospital should revert to the status quo in respect of smoking in the Hospital; there would continue to be no smoking in the new buildings; a range of options would be considered in the consultation on creating a smoke free environment; PFPI [*Patient Focus Public Involvement*] Co-ordinator... would prepare a draft consultation document for stakeholders; The opinions of all stakeholders would be taken into account and the [*Smoking Cessation*] Taskforce would promote the fact that the outcome of the consultation process would influence the final decision of the Board, ie that the aspiration for a total ban may then be modified, for example to a partial ban, depending on the feedback received.

The Board would discuss the outcome of the consultation at its meeting in June and their decision on smoking at the Hospital would be made at that time following consideration of the recommendations of the Taskforce."

The outcome of the initial consultation was a report by the joint assistant medical director, chair of the Smoking Cessation Task Force [7/12, minute of board meeting, 7 February 2011, 1, 2].

[76] Altogether there were three rounds of consultation. The first consultation ran from 1 March to 31 May 2011. The second consultation was directed at 73 patients who smoked. This took place in April 2011. This consultation asked smokers to express preferences for coping with the comprehensive smoke-free option. The second consultation is not founded on by either party. The third consultation took place in August 2011 after the closure of the smoking rooms in the existing hospital buildings and was described as a "feed-back" exercise about the "partial smoke-free" regime then in place. The third consultation is discussed below.

[77] Returning to the first consultation, it sought the views of patients, staff and carers in relation to two options, namely (1) "partial smoke-free", meaning smoking in designated areas within the grounds and (2) "comprehensive smoke-free" meaning no smoking internally or externally. The report on the first consultation is with the papers. Although it was not presented by Mr Campbell QC in oral submissions, it is the only consultation material founded on by the respondents in their *pro forma* replies to the letters of intimation of claim on behalf of the petitioner and others. At the time there were 136 patients in the hospital. Questionnaire forms were completed by 121 patients of whom 78 (64.5%) were smokers and 43

(35.5%) were non-smokers. The preferences were 104 (86%) for "partial smoke-free" and 17 (14%) for "comprehensive smoke-free". Questionnaire forms were completed by 55 carers of whom 46 (84%) opted for "partial smoke-free", 5 (9%) opted for "comprehensive smoke-free" and 4 (7%) expressed no preference. Only 36% of carers were smokers. Of the 205 staff respondents, a small majority (54%) opted for "partial smoke-free". There was a higher response rate for patient smokers — reckoned at around that time to account for slightly over half of the patient population — than for patient non-smokers. Clearly at that stage a substantial number of non-smokers, patients and carers, did not support "comprehensive smoke-free". It is difficult to see that the results of this consultation supported "comprehensive smoke-free" and, as I have said, the consultation was not founded on in submissions by Mr Campbell QC for the respondents [7/17(3), consultation report march 2011; 7/17(69)—(71); 7/20, report by joint associate medical director].

[78] Dr Fergus Douds MRCPsych, joint associate medical director and leader of the Smoking Cessation Task Force, wrote a report on the consultation with a recommendation to the respondents. This report was not referred to by senior counsel in oral submissions but it does seem to be an important part of the story. The report tells me that since the introduction of the hospital's smoking cessation service in 2004, rates of smoking in the patient population had already fallen from 78% to 52%. Since the beginning of 2011 the number of smoking cessation advisers had increased from 0.4 to 2.0 full time equivalents with initially promising results. The Task Force view was that it would be better to promote smoking cessation vigorously over a longer period than to impose change. The termination of internal smoking would assist. The proposed action plan was (1) to allow external smoking in the new hospital beyond the curtilage of ward and hub gardens; (2) to prepare for the change by closing ward smoking rooms in the existing buildings from Monday 1 August 2011 and by prohibiting smoking in existing ward gardens from the same date; (3) to continue to invest heavily in smoking cessation resources utilising the Scottish government grant; (4) to carry out a further review in August 2012 and to consider then whether a move to "comprehensive smoke free" would be appropriate [7/20, report by joint associate medical director — the seven appendices to the report have not been produced].

[79] The report was tabled at the board meeting of 23 June 2011. Dr Douds confirmed that the board had "made it explicitly clear that the consultation was only around two options", namely (1) moving to a totally smoke free hospital and (2) continuing to permit smoking in designated external areas within the grounds. The report recommended option (2). Matters discussed included the timeline for a totally smoke-free hospital; number of patients who smoked but did not have grounds access; the timing of the review of progress; patients' rights; the potential legal challenge. The board resolved to accept option (2) subject to

further consideration of how the partial smoking ban option would operate in practice and subject to there being no adverse feedback. The board also confirmed its full commitment to working towards a smoke-free hospital. On 5 July 2011 the board, "after careful consideration of the operational considerations and as no adverse feedback had been received", decided to adopt option (2). It was noted that the decision would be reviewed in November 2011 after the first three months in operation (rather than in August 2012 after twelve months in operation). It was noted that the board remained fully committed to working towards a smoke free hospital. As from 1 August 2011 smoking rooms within existing buildings would close and smoking would not be permitted in ward gardens. Smoking would only be permitted in designated external areas in the grounds (specified as "anywhere patients can walk that is covered by CCTV"). Senior counsel explained that the closure of the smoking rooms in the existing buildings was to prepare for the move to the new buildings where internal smoking would not be permitted. The move to the new accommodation was proposed to take place on 21 September 2011 [7/13, minute of board meeting, 23 June 2011, 2, 3; 7/17 (45), minute of Smoking Cessation Task Force meeting 6 July 2011].

[80] One of the challenges flagged up at the meeting of 23 June related to the number of patients who smoked but who did not have grounds access. At that stage the number appeared to be unknown. It seems that the first version of the "partial smoke-free" regime envisaged patients without grounds access being able to smoke in the grounds under escort only when it was possible for clinical teams to "facilitate" this on an individual basis. The chief executive subsequently reported that there had been "considerable problems experienced in operationalising the process, eg increasing numbers of higher risk patients had been referred for consideration of ground access". As a result, it seems, of this pressure the "Senior Team" had agreed that patients would continue to be permitted to smoke in ward gardens unescorted at eight points [*meaning* "times"] during the day agreed with the clinical team [7/17(44), minute of Smoking Cessation Task Force meeting 20 May 2011, 2; 7/17(84), smoking cessation resource pack, 3; 7/17(45), minute of Smoking Cessation Task Force meeting 6 July 2011, 1—2; 7/18, operational procedure; 7/15, minute of board meeting 25 August 2011].

[81] The third consultation took place in mid-August 2011 following the closure of the smoking rooms. This was intended to gather feed-back about the partial smoke-free regime. Mr Campbell QC referred me to the summary of questionnaire results for patients and staff. Of 82 patient respondents, 52 (63%) favoured the partially smoke free option and 29 (35%) favoured the totally smoke free option. There were no other choices. I note that 43 (52%) of the patient respondents were smokers and 39 (48%) non-smokers. I deduce that all 43 smokers and nine non-smokers favoured the partial smoke-free option. Of the 43 smokers, 29

had grounds access and 14 did not [7/16, post-smoke room closure consultation with patients].

[82] I have now had an opportunity to look more closely at the collated results of the "post smoke room closure patient feedback forms" and their interpretation by the respondents to this petition. The additional comments highlighted a grievance among non-smokers about smoking in the ward gardens. It was said that the ward gardens had effectively become smoking rooms; and there is a hint that the feed-back was commissioned to capture what was hoped to be growing opposition of non-smokers and staff to the "partial smoke-free" solution. There were complaints about the disruption of ward routines to accommodate smoke breaks. There were complaints from smokers that some wards gave fewer or shorter smoke breaks than others. The State Hospitals Board made the following claim about the feedback: "In the first consultation (March to May 2011) 14% of patients had stated a preference for a comprehensive smoke-free environment, however this increased significantly by 11.8% [sic] to 35.8% in this latest and final consultation (August 2011)." This finding was also presented in graph form. In fact the "increase" in support for "comprehensive smoke-free" was from 17 (14%) on a total sample of 121 patients to 29 (35.4%) on a total sample of 82 patients and might have been accounted for wholly by non-smokers, of whom 39 completed the questionnaire. The chief executive's report for the meeting of 25 August 2011 referred to staff questionnaires, 82 of which had been returned. One questionnaire had been incorrectly completed. Eighteen respondents (22%) favoured the continuation of the partial smoking ban and 63 respondents (77%) favoured a complete ban [7/15, 2 chief executive's report 25 August 2011; 7/16, appendix to chief executive's report 25 August 2011; 7/17(46), minute of Smoking Cessation Task Force meeting 5 August 2011, 2; 6/1, "Working towards a smoke-free environment: an account of the journey undertaken by The State Hospital" (The State Hospital/NHS Scotland, February 2012), 12—13].

[83] At the board meeting of 25 August 2011 the chief executive also reminded members of the board's full commitment recorded at previous meetings to working towards a smoke free hospital. The ensuing discussion and decision was minuted as follows [7/14, 3]:

"Members noted that the decision taken in June 2011 was to be reviewed in November 2011. The documented feedback which had been received over the course of August 2011 from staff, as well as from smoking and non-smoking patients was reviewed. The discussion that followed centred around the difficulties encountered with the partial cessation of smoking at the Hospital in relation to issues of safety and security, operational and clinical disruption, time demands on staff, fairness of the partial restrictions, and the inconsistencies around the set points in the day when smoking was permitted. Members noted that the General Manager had reviewed the operational requirements to comply with the Board's original decision only in designated areas outwith the new hubs and clusters and confirmed his commitment to resourcing this for a limited period.

In the light of the difficulties discussed and the importance of the operational management's view, Members agreed that the partial cessation of smoking at the Hospital had proved unworkable despite the best efforts of staff involved. It was agreed that The State Hospital would be a full

non-smoking environment as of 1 December 2011..."

Senior counsel told me that the documentation up to and including 7/16, "post smoke room closure consultation with patients", was the material that the respondents had in mind when they decided on the complete smoking ban effective from December 2011. He did not refer to any other documentation in explanation or justification of the decision. In particular there is nothing else to justify or explain why the petitioner, who had and has grounds access, has been prevented from smoking in the State Hospital grounds.

[84] The proposition that a comprehensive smoke-free policy was, from at least 2007, integral to the plans for the new hospital and the regime to be operated there is well-evidenced by the document produced in February 2012, "Working towards a smoke-free Environment". In the "Background" section I find it stated [my emphasis]:

"Due to the poor physical condition of the estate and obligations to meet these statutory requirements, a Full Business Case for the re-development of The State Hospital was approved by the Scottish Government in September 2007... As part of the Full Business Case, approved by the Scottish Government, the new Hospital would be a smoke-free environment with no provision for smoking internally or externally. *This meant there would be no dedicated smoking rooms and patients would not be permitted to smoke in gardens or grounds.* This was reiterated to stakeholders at the time of consultation."

The "statutory requirements" referred to are the supposed requirements in terms of the Mental Health (Care and Treatment) (Scotland) Act 2003 discussed above. I deduce from all that was said to me during the hearing that the "stakeholders" who were consulted at the planning stage did not include the patients: the patients were recognised as "stakeholders" only when it came to designing the process for implementing the smoking ban already decided on [6/1, "Working towards a smoke-free environment: an account of the journey undertaken by The State Hospital" (The State Hospital/NHS Scotland, February 2012), 1 and 4].

[85] In a message to staff about the decision of 25 August 2011, the chief executive stated:

"The long term view was always to put in place a 'Totally Smoke Free Environment', this is in keeping with the vast majority of other health Board Establishments. Whilst the Garden Areas attached to existing wards, can be used, in the new build these areas are not suitable, and have not been designed with smoking in mind."

Reading this in the light of the above description of the "Full Business Case for the re-development of The State Hospital... approved by the Scottish Government", I am inclined to interpret the reiterations by the board during 2011 of its "full commitment to working towards a smoke-free hospital" as meaning that, for management, the "comprehensive smoke-free" end result was always a foregone conclusion. There are

hints in the contemporary documentation that whatever patients thought was meant by "consultation", from management's point of view, the consultation exercise might assist in achieving, but would not deflect from, the desired result [7/17(77), message from chief executive 25 August 2011; 7/17(40), minute of Smoking Cessation Task Force meeting 11 February 2011, 3.10; 7/17(11), minute of PPG smoking consultation 10 March 2011, 1, 4; 7/17(43), minute of Smoking Cessation Task Force meeting 21 April 2011, 2].

[86] Almost as soon as the decision was made to abandon the first version of "partial smoke-free", whereby all smokers were to smoke in the grounds, and to implement an alternative version by permitting smoking by all smokers in the ward gardens of the existing buildings (to accommodate patients without grounds access), it became apparent that there would be difficulty in continuing the "partial smoke-free" policy in the same way in the new buildings. At the meeting of the Smoking Cessation Task Force on 5 August 2011:

"There was great concern that the new ward gardens within the hubs could not be used for smoking given that there was currently no standing area within those gardens and that there was also the prospect of the plastic decking being ruined by cigarettes. In addition there is no external lighting in the hub gardens, meaning that in the winter patients would not be able to smoke outside when it was dark. [The security manager] expressed the view that a partial smoking policy without access to the gardens would simply not be workable... "

When the move to the new buildings took place, a third version of the "partial smoke-free" regime was put in place [7/17(46), minute of Smoking Cessation Task Force meeting 5 August 2011, 2].

[87] The third version of the "partial smoke-free" regime was implemented on 21 September 2011 and continued until "comprehensive smoke-free" was enforced on 5 December 2011: (1) patients with grounds access, i.e. unescorted grounds access, were permitted to have continuous grounds access from 0900 until 1900 (with earlier cessation during winter months) and to smoke at all times during access in designated grounds access areas; (2) patients without grounds access were permitted to smoke in hub gardens, under observation, at five defined times during the day starting at 0930 and finishing at 1830 (with earlier cessation during winter months) or, if unable to access hub gardens at defined times for clinical reasons, patients without grounds access were to be clinically assessed for individualised access to hub gardens at other times; (3) newly admitted patients were to be assessed individually for smoking cessation support and access to smoking. The five defined "set points" for patients without grounds access were intended to remove inconsistencies and perceived unfairness in the way different wards operated the regime. [7/20, operational procedure; 7/17(34), PPG update 15 September 2011; 7/17(35), PPG update 22 September 2011; 7/17(36), PPG update 29 September 2011; 7/17(37), PPG update 6 October 2011; 7/17(82), Moving Toward a Smoke Free Environment (patients); 7/17(83), operational procedure (staff)].

[88] As regards patients like the petitioner with grounds access, the only issue identified with the third

version of the "partial smoke-free" regime was whether grounds access patients should be permitted to use hub gardens for smoking during the last "set point" of the day after cessation of grounds access. Access to hub gardens by grounds access patients at this time was supported by some of the senior management team [SMT]. I think I am right in saying that treatment was equalised by allowing grounds access patients to smoke in the grounds from 0900 throughout daylight hours and by removing the last "set point" for hub gardens smoking when grounds access was restricted during winter months. The notices for patients emphasised that only patients without grounds access would be permitted to smoke in hub gardens. Two fixed electronic lighters were provided for grounds access patients, one of which was at low level for disabled (presumably wheelchair-bound) smokers [7/17(47), minute of Smoking Cessation Task Force 8 September 2011; 7/17(74), minute of PPG meeting 14 July 2011; 7/17(33), PPG update 8 September 2011, 2; 7/17(35), PPG update 22 September 2011; 7/17(36), PPG update 29 September 2011; 7/17(39), PPG update 6 October 2011].

[89] The petitioner insists that during the "partial smoke free" regime there were no problems with him using his grounds access for smoking his cigarettes. I simply could not reconcile his position with what the respondents were saying about difficulties over "safety and security, operational and clinical disruption" and so on — that is until I had looked at the documentation about the evolution of the "partial smoke-free" regime. It is possible for both parties to be right, understanding that the respondents are referring to the position as at 25 August 2011 and that the petitioner is referring to the position after 21 September 2011. On this understanding, looking at matters following the move to the new buildings when the third version of "partial smoke free" was in place, there is disclosed, and I can discern, no rational basis for the respondents, in pursuit of the declared aim of protecting others from his cigarette smoke, to have stopped the petitioner smoking in the hospital grounds.

[90] Had there been problems, you might have expected the respondents to consult with patients in a quest for possible solutions. At the Smoking Cessation Task Force meeting of 5 August 2011 the Patient-Focus-Public-Information [PFPI] coordinator expressed the view that: "it was important to ask patients to contribute to how the organisation could safely and practically operationalize smoking policies". There is no evidence of this having been done after 21 September 2011 [7/17(46), minute of Smoking Cessation Task Force meeting 5 August 2011, 2].

Chronology of the claim

[91] Senior counsel for the respondents reminds me that the respondents' decision to go "comprehensive smoke-free" with effect from 1 December 2011 was made by the respondents at their meeting on 25 August 2011. I am invited to accept that the decision was communicated to patients no later than

1 September 2011. Because of unrelated industrial action by staff the implementation date was put back to 5 December 2011. The respondents did not hear formally of the petitioner's intention to make a claim until five months after that. Claims have been intimated on behalf of five patients. Senior counsel contrasted the petitioner's position with the actions taken by the other patients. The petitioner's claim was the last to arrive.

[92] The first evidence of any claim relates to the earlier proposal for a smoking ban effective from 16 May 2011. A copy legal aid application relating to judicial review of the decision to go smoke free on 16 May 2011 was intimated to the NHS Scotland Central Legal Office on 1 February 2011. This was on behalf of the patient C C. The nominated solicitor was Francis J Irvine of Frank Irvine Solicitors Ltd, Glasgow. The burden of the complaint, as far as I can tell from an incomplete copy, was breach of article 8 ECHR, failure to consult and non-compliance with section 1 of the 2003 Act. The application was apparently not proceeded with at that time, possibly because of the respondents' decision to rescind the plan to go "comprehensive smoke-free" in May 2011 [7/24/1—3 (incomplete)].

[93] The reaction of patients to the proposed smoking bans should perhaps be set in the context of the legal information and advice given by the respondents during 2011. It is recorded that:

"Patients continually referred to the pending legal injunction which they hoped would allow them to continue to smoke on a partial basis indefinitely. The appeal was unsuccessful however many smoking patients still believed some form of legal intervention would happen that would either postpone or stop the move to a comprehensive smoke-free environment on 5 December 2011.

It was explained to patients that it was very unlikely that such an intervention would occur, and in the absence of this, the planned move to a comprehensive smoke-free environment was forthcoming and the decision to go totally smoke-free would not be reversed."

This is the account of matters written shortly after the event. I think the reference to a "pending legal injunction" and an "unsuccessful appeal" might be a reference to the *R (N)* case in England, or it could possibly be a reference to an unsuccessful application, for example by Mr C C, to review a refusal of legal aid. I infer that the NHS Scotland Central Legal Office, on behalf of the respondents, made counter-representations to all legal aid applications in connection with the smoking ban [6/1, "Working towards a smoke-free environment: an account of the journey undertaken by The State Hospital" (The State Hospital/NHS Scotland, February 2012), 13].

[94] Some documents that pre-date the smoking ban contain a record of legal advice given to patients by the respondents at the time. At the Patient Partnership Group [PPG] meeting of 10 March 2011 — ten patients in attendance — the leader of the Smoking Cessation Task Force explained that patients should not regard the hospital as their "home" since patients ought to have the long term goal of proceeding to

less secure environments. He also rejected the argument that compelling patients to stop the lawful activity of smoking was a matter for the police and advised that patients could "utilise their solicitors to process such grievances". At the PPG meeting of 31 March 2011 — six patients in attendance — patients were told: "It is NOT a human right for anyone to be allowed to smoke." At the PPG meeting of 14 July 2011 during the "partial smoke-free" regime some frequently asked questions were addressed, including the following:

Q Can the State Hospital be exempt from the partial ban on smoking on mental health grounds?
 A There is no exemption for the State Hospital; this is a Scottish Office decision.
 Q Is being able to smoke a Human Right?
 A No, this was challenged in the European Courts and the ruling was that this is a 'privilege' not a right?
 Q Are there any challenges on the partial smoking ban being made from the State Hospital?
 A No."

Clearly the reference to "no exemption for the State Hospital" was erroneous since the statutory exemption remained and remains in force. The reference to smoking being a privilege rather than a right may have been derived, mis-remembered, from the national guidance document issued in February 2011. The document advises service providers to "de-bunk myths robustly". Under the heading "Debunking the myth that smoke-free policies breach smokers' human rights" it is stated: "... the legal precedent for support for smokers' rights has been almost non-existent, with tobacco use deemed in courts throughout the US to be a privilege rather than a right, and to be restricted when it is detrimental to others". [7/17(11), note of PPG meeting of 10 March 2011, 3, 4; 7/17(12), note of PPG meeting 31 March 2011, 2; 7/17(74), note of PPG meeting of 14 July 2011, 2; 7/22, *Smoke-free mental health services in Scotland: implementation guidance* (NHS Scotland, February 2011), 35, 36].

[95] At the meeting of the PPG on 8 September 2011 the advice given included the following:

"Several patients felt that smoking should be stopped before moving into new hospital environment and asked why we had to wait till 1st December for a smoke free environment, [Smoking Cessation Advisor] advised that legally hospital needs to wait for three months as per review/consultation period.

...

Patients advised that under Scottish Law a partition [*class action?*] cannot be herd [*sic*] and only individual cases against hospital policy can be reviewed.

Patient raised concern about individual challenging although other peer had no concern

...

Patient group advised that [*Working towards a Smoke Free Environment*] is a Scottish Government Directive and each Health Board has to introduce a working towards a smoke free environment."

Smokers had apparently been advised before the PPG meeting of 8 September 2011 that if they disagreed

with the respondents' smoke-free policy they could try and resolve issues at ward level or by discussing it with a member of their care team. They were also reminded of their right to complain: "The Advocacy Service is well placed to help you with this or you can write to the Complaints Department". At the beginning of 2011 the Patient Advocacy Service [PAS] had coordinated an anti-smoking-ban petition. The petition had been presented to management with apparently no effect. There is no evidence of any PAS involvement in the smoking debate after that [7/17(5)—(6), note of PPG meeting 8 September 2011; 7/17(84), Smoking Cessation Pack (July 2011), 4; 7/17(10), note of PPG smoking update meeting 19 January 2011, 2; 7/17(15), note of PPG meeting 20 January 2011; 7/17(65), note of Clyde Ward meeting 27 January 2011].

[96] The question of individual patient litigants being identified had been raised before, in February 2011, just after the respondents received intimation of CC's first legal aid application. It is possible that the concern was about being identified to the public at large. When Lady Dorrian's judgment in *L Petitioner* was issued the successful applicant was named and identified in the media as a child rapist. It was suggested at that juncture that it would be preferable to have a group action about the smoking ban to protect identities [7/17(5) — (6), note of PPG meeting 8 September 2011; 7/17(40), § 10.2].

[97] Senior counsel refers to the 25 August 2011 decision to go "comprehensive smoke-free" being communicated to patients "no later than 1 September 2011". I was told that "a notice" was displayed in all wards. This must be a reference, I think, to the notice of 1 September 2011 "What's going on at the PPG on 8 September". The PPG notice is a sort of agenda for the meeting scheduled for 8 September 2011. The item for discussion in the afternoon was: "PM - Working towards a smoke free environment". The notice contains a message from the chief executive as follows:

"As you know, as of 1 August 2011, the smoking rooms in the Hospital have been closed and a partial smoke free environment was put in place, i.e. smoking in the grounds.

Over the course of the month of August, significant operational and security risks have come to light.

Extensive feedback was available to the Board from patients and staff and after careful discussion at their meeting today (25th August 2011), it has been decided to implement a full smoke free environment as of 1 December 2011."

The "comprehensive smoke-free" message was reiterated in the "What's going on at the PPG" notices for the meetings of 15 September (issued 8 September) and 22 September (issued 15 September). The notice of the PPG meeting of 29 September (issued 22 September) detailed the "partial smoke-free" regime for the period from 21 September 2011 to 1 December 2011. The same is true of the notices for the meetings of 29 September 2011 and 8 October 2011 [7/17(32)—(36)].

[98] The PPG meeting of 8 September 2011 was attended by eight patients. Four of the six wards were represented. According to the record, there was discussion of the fact that the management intended the hospital to be "comprehensive smoke-free" from 1 December and it does appear that this was understood by the patients present. There is also a note on 15 September 2011 that "over the next few weeks" a member of the smoking cessation team would speak to all smokers to ensure that they were aware of the situation on and from 1 December 2011. The petitioner claims to have been unaware that a complete ban was intended "for a substantial time" after the decision of 25 August 2011. He does accept that he was aware five or six weeks before 1 December 2011 — ie sometime in October 2011 — that a complete ban was intended. I should be surprised if the petitioner were not aware, by 1 October 2011, of what was meant to happen on 1 December 2011 at latest. (In January and February 2011 there had already been one well-publicised "count down" to the original smoke-free deadline) [7/17(74), 5—6; 7/17(81), email 15 September 2011; Record no 13 of process 12 February 2013, 6D-E; 7/17(18), PPG update 3 February 2011].

[99] By letter dated 3 October 2011 Frank Irvine Solicitors Ltd, Glasgow, acting this time for another patient D M, wrote to the respondents' chief executive stating that they had instructions from "a number of patients" who objected to the "blanket smoking ban". The solicitors asked for confirmation by return of the proposals for the ban and requested details of consultations and "copies of all official notifications or publications in relation to the proposed smoking ban". The matter was said to be urgent. By letter dated 13 October the respondents' chief executive replied, confirming that the State Hospital would become "a smoke free environment" as from 5 December 2011. The letter stated: "A comprehensive consultation was undertaken over a three month period (1 March to 31 May 2011) involving patients, carers and all other stakeholders." (This was the first consultation referred to above.) The letter concluded:

"Our move to becoming a smoke free environment is in line with NHS Scotland policy. As a hospital one of our core objectives has to be health promotion and there is compelling international evidence about the inherent risks of exposure to passive tobacco smoke. We have a duty of care to protect our non-smoking patients (50% of the patient population) from passive smoke, as well as all of our staff and other visitors."

This became the *pro forma* response to claims with one alteration, namely that the words in brackets about "50% of the patient population" were in due course omitted. Senior counsel told me that no petition had been lodged on behalf of D M. Whether this is because legal aid, or full legal aid, was refused or because D M is now happy to be a non-smoker or has died or has been discharged or transferred out of the system I do not know [7/25/1—2].

[100] By letter dated 25 October 2011 the Scottish Legal Aid Board [SLAB] notified the Central Legal Office

of another application by C C for legal aid for judicial review of the "blanket prohibition" on smoking in the wards and grounds "as of December 2011". As before the solicitors were Frank Irvine Solicitors Ltd, Glasgow. Even from the incomplete copies which I have of the statutory statements supporting the previous application for C C and this application, it seems that these were very fully argued cases. Senior counsel tells me that no petition has been lodged. Again, I have no explanation [7/24/4—6 (incomplete)].

[101] By letter dated 3 November 2011 McKennas Law Practice, solicitors, Glenrothes, intimated a claim to the respondents on behalf of the patient AR. The letter states:

"Our client has asked us to intimate a claim on his behalf against the State Hospital with regards to a breach of his human rights to have a private life and his right to smoke within the precincts of the State Hospital... We understand that there are certain test cases currently ongoing and we should be obliged by your confirming the hospitals current policy in relation to this matter..."

This wording became *pro forma* for the McKenna Law Practice smoking-ban claims letters. In her *pro forma* reply dated 9 November 2011 the respondents' chief executive confirmed that the State Hospital would become "a smoke free environment" as from 5 December 2011, etc. The letter did not answer the question about "test cases".

[102] After a follow up letter from McKennas Law Practice, the respondents by letter dated 1 December 2011, confirmed that the letter of 3 November was being treated as an intimation of claim and that the matter had been passed to the Central Legal Office. There may be correspondence that has not been produced: but it seems that in response to a letter from the Central Legal Office dated 6 January 2012, McKennas Law Practice repeated the question, this time to the Central Legal Office: "whether or not there are indeed any test cases ongoing at the moment..?" This was on 12 April. There seems to have been a repeat request on 14 May and a further request on 27 June [7/28/1—7].

[103] By letter dated 5 December 2011 McKennas Law Practice intimated a *pro forma* claim to the respondents on behalf of the patient W M. In particular the letter on behalf of W M stated: "We understand that there are certain test cases currently ongoing and we should be obliged by your confirming the hospitals current policy in relation to this matter..." The respondents' chief executive sent the *pro forma* response on 13 January 2012. On the same day, it seems, the respondents' claims officer wrote to the Central Legal Office asking about "test cases". The Central Legal Office replied on 1 February 2012 as follows:

"My understanding was that Frank Irvine, Solicitors, on behalf of another patient, intended raising judicial review proceedings in the Court of Session. I have heard no further from them; it may be that these cases [*sic*] will not proceed. Certainly, from informal conversations with [*the respondents' chief executive*] it would appear that the smoking ban is causing no problems."

By letter of the same date to McKennas Law Practice, the Central Legal Office stated: "At the moment,

there is no so called "test case" that I am aware of" [7/27/1—4].

[104] By letter dated 1 March 2012 McKennas Law Practice intimated a *pro forma* claim to the respondents on behalf of the patient J J. In particular the letter on behalf of J J stated: "We understand that there are certain test cases currently ongoing and we should be obliged by your confirming the hospital's current policy in relation to this matter..." The respondents' chief executive sent the *pro forma* response on 12 March 2012. On 28 March 2012 the Central Legal Office followed up the chief executive's response with a letter to McKennas Law Practice stating: "I am unaware of any test cases relating to the right to smoke within the State Hospital, at the moment." On 17 April 2012 McKennas Law Practice asked the Central Legal Office: "We should be obliged by your confirming whether or not J J's case is going to be considered as suitable for a test case in relation to the right to smoke in the State Hospital?" The Central Legal Office's response dated 24 May 2012 stated: "The position is as described to you in my letter of 28 March 2012."

J J's legal aid application was intimated to the Central Legal Office by SLAB on 2 October 2012 [7/26/1—10].

[105] It seems that the petitioner first contacted McKennas Law Practice about the smoking ban on 8 March 2012. Under cover of a letter dated 10 March 2012 the solicitors sent a legal advice and assistance form to the petitioner for completion. The form was returned about two weeks later with the declaration on the second page unsigned. McKennas Law Practice returned the form to the petitioner under cover of letter dated 29 March 2012. The form was apparently signed by the petitioner on 2 April 2012. Legal aid for advice and assistance was granted on 10 April 2012 [6/7—6/9].

[106] The first intimation of claim was made by *pro forma* letter dated 3 May 2012. Intimation of the petitioner's full civil legal aid application was received by the respondents by letter from SLAB dated 31 May 2012. The application was for legal aid for judicial review proceedings of the respondents' decision made on 5 December 2011 to prohibit smoking within the State Hospital and in the grounds and to prohibit patients from smoking beyond the State Hospital [7/1; 7/2].

[107] By letter dated 18 June 2012, four days late, counter-representations were made to SLAB by the Central Legal Office on behalf of the respondents. On 25 July 2012 SLAB sought further information from McKennas Law Practice. On 15 August 2012 the petitioner's application was refused. McKennas Law Practice then sought an increase in advice and assistance funding which was granted on 29 August 2012. On 20 September 2012 a refusal review request was submitted and the submission was notified by SLAB to the Central Legal Office. The review was successful and SLAB issued the certificate on 12 November 2012. By letter of the same date SLAB notified the Central Legal Office that the petitioner's application for legal aid for judicial review had been granted. The petition for judicial review was lodged on 30 November 2012 and first orders were granted on 5 December 2012. As at February 2013 it appears that the petitioner

remained on nicotine replacement therapy. He claims that he still wants to smoke [6/14—6/20; 7/4; 7/6; 7/7; Minute of Amendment no 14 of process].

[108] It appears from the pleadings that petitions at the instance of W M, J J and A R were presented to the court on 4 December 2012. First orders were also granted on 5 December 2012. The W M and J J petitions have been sisted pending the outcome of the present proceedings. A R is no longer a patient, having been transferred to prison: I am told that the proceedings at his instance are now an action for declarator and Convention damages involving substantially the same grounds of complaint [Record 12 February 2013, no 13 of process]. I understand from submissions on both sides that none of the other applications has been or is to be met with a plea of *mora*, taciturnity and acquiescence.

Mora, taciturnity and acquiescence

[109] The respondents' plea of *mora*, taciturnity and acquiescence has to be decided first: if that plea is sustained, there is no need to consider the merits. In public law the plea of *mora* supports a bar to action on grounds of expediency in the public interest. Mr Campbell QC puts it as follows: "The public interest in good administration means that public authorities should not be kept in suspense longer than necessary." I take it that what is "necessary" on this formulation is a period of time that is judged adequate in all the circumstances for bringing the challenge. The current legislative proposal is for a time limit of "three months beginning with the date on which the grounds giving rise to the application arose or such longer period as the Court considers equitable" [Rt Hon Lord Clyde and D J Edwards, *Judicial Review* (Edinburgh, 2000), §§ 13.20—13.25; Lord Gill, *Scottish Civil Justice Review*, vol 2, chap 12, § 39; Draft Courts Reform (Scotland) Bill s. 27A].

[110] To support the traditional plea of *mora*, however, it is usually said that the mere running of time is not enough: there must be inaction and lack of complaint for such a period and in such circumstances as supports the inference of acquiescence in the decision at issue. Parties are agreed that the principles for deciding the plea are as set out in the *Portobello* case. The delay in the *Portobello* case was almost four months, at least, and was arguably much longer [*Portobello Park Action Group Association v City of Edinburgh Council* 2012 SLT 1137 at §§ 13—22, *per* Lady Paton delivering the opinion of the court].

[111] I remind myself that the plea of *mora* is, as Mr Campbell QC submits, a procedural defence. Although the concepts merge, it is not the same as waiver. Waiver expresses the unequivocal renunciation of the right in issue. The respondents in this case do not plead that the petitioner has renounced his rights, simply that he is precluded from enforcing them. In my view, factors relevant to an assessment of the plea include the nature of the alleged impropriety: is it a mere reasoning or process error; or is it the

infringement of a substantive right or an act that is substantively *ultra vires*. No amount of acquiescence can make an *ultra vires* act *intra vires*. The public interest in sound administration argues at least as much for keeping administrative decision-makers within the proper bounds of their powers as it does for allowing them to close the book on past mistakes. I agree with Mr Leighton for the petitioner that, while prejudice is not essential, at least where waiver is in issue and possibly also when acquiescence is alleged, the plea of *mora* is particularly apt where "time is of materiality", as where the decision under challenge is time-limited in its effect or, I would add, where the decision is the basis for further action or decision-making [*Somerville v Scottish Ministers* 2007 SC 140 at § 94 *per* Lord President; Rt Hon Lord Clyde and D J Edwards, *Judicial Review* (Edinburgh, 2000), § 13.23; *Watt v Secretary of State for Scotland* [1991] 3 CMLR 429 at § 21].

[112] It is for the respondents to make the plea out. For the respondents Mr Campbell QC submits that it must have been obvious to the petitioner from September 2011 that he could bring a legal challenge. It was known throughout the hospital that the respondents' prohibition on importing foodstuffs had been successfully challenged. Other patients made an early challenge to the smoking ban. The petitioner had "interacted" with the Mental Health Tribunal at some stage in the past. The Patient Advocacy Service was at his disposal. Senior counsel submits that elements of delay, taciturnity and acquiescence are all demonstrated. The petitioner's submission that the smoking ban is not just a past violation but an ongoing violation of his article 8 ECHR rights is described by senior counsel as "a category error".

[113] Mr Leighton for the petitioner submits that although the petitioner had notice of the smoking ban he was not given the reasons. The minutes of the respondents' board meetings did not become available until after proceedings were raised. (It does seem that the relevant decisions were made in private session, the minutes of which are not published.) The respondents clearly changed position several times. The petitioner was entitled to wait and see if the total smoking ban actually became effective. Any delay on the petitioner's part has not prejudiced the respondents. They were aware of a number of similar challenges ongoing. The *Portobello* case demonstrates that account has to be taken of "the considerable difficulties" which litigants who wished to challenge administrative decisions face. There were hurdles in the way of the petitioner getting a solicitor and consulting with a solicitor. For reasons that are perhaps not entirely clear, the plea of *mora* seems to have heightened application in judicial review of administrative decision-making as compared with claims by ordinary action: but this should not necessarily be so where substantive rights are at issue.

[114] Counsel referred to the case of *Ruddy*. Kevin Ruddy was arrested and allegedly assaulted by the police on 5 September 2004. Mr Ruddy did not bring his claims for damages until a date in August 2005.

His claims were brought by ordinary action at common law and under section 8(3) of the Human Rights Act 1998: no plea of *mora* was taken [*Ruddy v Chief Constable, Strathclyde Police* (S) 2013 SLT 119]. Likewise A R is proceeding by way of ordinary action to, in effect, challenge the respondents' smoking ban. Counsel submits that the respondents' plea of *mora* fails to recognise that there are two components to the petitioner's claim, a challenge to the decision-making and a complaint about the ongoing prohibition by which the petitioner is prevented from smoking day by day. The clock has not yet started to run.

[115] There are a number of questions which might have been usefully answered. Why did the petitioner's agents keep asking whether "test cases are currently ongoing" when the response was either silence or in the negative? Why didn't they intimate the petitioner's claim as soon as they had instructions? As for the petitioner, why did he wait for three months after his last cigarette before contacting a solicitor? These are matters that might have been clarified by affidavit evidence but no affidavits have been offered. Senior counsel for the respondents generously accepts that rumours about the C C and D M claims may have given rise to the idea of "test cases". On this basis the delays on the part of the petitioner and his solicitors begin to become intelligible, particularly given the concern expressed by patients about the negative publicity which might be involved for them as individuals if they were to take legal action. (Senior counsel did not say whether the C C and D M claims had ultimately foundered because legal aid was refused.)

[116] Leaving aside the question of an ongoing infringement, the most favourable view of the petitioner's situation is that he delayed from 5 December 2011 to 8 March 2012, a period of just over three months, 8 March 2012 being the date when he first consulted a lawyer. I am prepared to take the favourable view. His delay ought fairly to be seen against a background of limited information, where some of the information emanating from the respondents was potentially misleading. I deduce that the only document offering an explanation of the decision-making available to the petitioner and his advisers before proceedings began was "Working towards a smoke-free environment: an account of the journey undertaken by The State Hospital" (The State Hospital/NHS Scotland, February 2012), 6/1 of process. This is available on the internet. If "considerable difficulties" confront activists in the outside world, how much more so must mental health detainees be disadvantaged in bringing a claim to court? It is not unreasonable to expect a detained patient like the petitioner subject to compulsory measures to have tried the respondents' smoking cessation therapy with "support" for a certain period before deciding to contest the ban. According to the petitioner's averments, he continued on nicotine replacement therapy and was continuing even at the date of his latest amendment (effected 14 February 2013). Although the averments are met with a general denial I am prepared to accept, in the absence of explanation from the respondents, that what the petitioner says about this matter is true. The inference must be that he had not succeeded in

overcoming his smoking habit [cf. 7/23 smoking cessation flow chart].

[117] The nicotine replacement therapy was a medical intervention on prescription. The respondents and their medical staff were therefore bound to know, because they were bound to comply with section 1 principles in this regard, that the petitioner did not wish to have nicotine replacement but, rather, that he wished to smoke. (The respondents themselves acknowledge that there was a question about the clinical propriety of using nicotine replacement therapy [NRT] to support "Cut Down To Quit" [CDTQ] although it is perhaps not clear that the concerns applied once cigarettes had been withdrawn altogether) [6/1 "Working towards a smoke-free environment: an account of the journey undertaken by The State Hospital" (The State Hospital/NHS Scotland, February 2012), 8—9; 7/20, operational procedure; 7/23 smoking cessation flow chart].

[118] There was some basis for the petitioner to think that the matter might be resolved by a test case. It was not until 1 February 2012 that McKennas Law Practice — who came to act for the petitioner a few weeks later — were informed that there was no test case "at the moment". The respondents had been advised as early as 2010 to expect a legal challenge. When the petitioner first consulted his solicitors, on 8 March 2012, the A R, W M and J J claims were ongoing. Senior counsel for the respondents does not contest that J J's claim is timeous: J J's claim was intimated on 1 February 2012. Having regard to all the circumstances, and given that the other claims already intimated were also directed at overturning the comprehensive ban as it applied to all patients including this petitioner, I think it would be not be reasonable, looking at the matter objectively, to infer acquiescence. Some significance must also be attached to the fact that when, on 18 June 2012, the respondents objected to this petitioner's full legal aid application, they did not mention delay as a ground for refusal. I shall repel the respondents' plea of *mora*, reserving my opinion on the argument about the effect of an ongoing infringement.

The merits of the claim

[119] Statute law and national policy, as quoted above, recognise smoking as an activity belonging to the private sphere, a sphere from which the state and state agents are excluded. Individuals are entitled to make their own choices about smoking, provided there is no harm to others. Law and policy also recognise that it is inappropriate to insist on the full rigour of prohibition where individuals are compelled to reside, by circumstances or by force of law, in otherwise smoke-free premises. In my view the decision to build a smoke-free hospital was a questionable one given the legal and policy context at the time. By making that decision the respondents tied their own hands and put it beyond their power to take advantage of the exemption allowed to psychiatric in-patient premises by the smoking legislation.

[120] The exemption for psychiatric in-patient premises was one of a number of exemptions motivated by considerations of, I infer — the matter is not well explained — not just principle, but also by expediency and compassion, mixed in different proportions, depending on the function of the premises. The principle is that the state has no business interfering in the private, domestic and family life of individuals by stopping them smoking — indulging in the vice of smoking, if you like — in their own homes and elsewhere where there are currently no recognised public health issues. The official guidance issued at the time recognised "the adult's right to buy and smoke tobacco". The guidance for mental health service providers emphasises: "... smoke-free policies are not moral statements; they restrict **where** and **when** people can smoke rather than restricting the choice of whether to smoke or not." The legitimate aim which has animated the state's interference with the "right to smoke" has been to protect others against second-hand smoke, not to stop smokers smoking. Accordingly, where individuals who smoke are compelled by circumstances or by law to reside long-term in otherwise no-smoking premises then the legislation recognises a case for treating such premises as their home and allowing them to smoke in a controlled way [7/21, *Smoke-free Scotland: guidance for the NHS, local authorities and care service providers* (2005), 13, 19—20, 26; *R (N) v Secretary of State for Health* [2009] HRLR 31, 927 at § 107 *per* Keene LJ dissenting; Secretary of State for Health during the third reading of the Health bill, *Hansard* 14 February 2006, cols 1293—1294, quoted in *R (N) v Secretary of State for Health* [2009] HRLR 31, 927 at appendix A § 20; *Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland*, 27 March 2013, ministerial foreword].

[121] I deduce that expediency was a consideration from two facts. First, the government has been noticeably cautious about banning smoking in prisons and has no immediate plans to do so because, I assume, of anxiety, such as has been voiced in England & Wales, about the possibility of disorder [*R (N) v Secretary of State for Health* [2009] HRLR 31, 927 at § 83 *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ]. Secondly, in the lead up to the smoking ban at the State Hospital opposition was expressed on the basis of a perception that increased aggression levels would result.

[122] The foreword to *Smoke-free Scotland* (2005) recognises the "humanitarian challenges" that have to be faced in the implementation of smoking bans. The exemption permitted to adult hospices is explained on "humanitarian", what I would call "compassionate" grounds. During the consultation in England & Wales a key stakeholder strongly supported the exemption for hospices on the ground that, in the case of lifelong smokers, to ban smoking would be contrary to the purpose of improving the quality of life. The petitioner in the present case argues his position on compassionate grounds: he avers that there are few diversions available in the State Hospital; that he derives pleasure from smoking; and that as an individual with relatively few liberties the removal of his ability to smoke has had a disproportionately large impact [7/21,

Smoke-free Scotland: guidance for the NHS, local authorities and care service providers (2005), 1, 6, 20; *R (N) v Secretary of State for Health* [2009] HRLR 31, 927 at § 87(iii) and (iv) *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ; art. 20 added by Minute of Amendment no 14 of process].

[123] Senior counsel for the respondents submits that the smoking ban at the State Hospital is in accordance with national policy. I disagree: there is nothing in national policy that countenances achieving "comprehensive smoke-free" for potentially exempt groups, ie residents in potentially exempt premises, by compulsion. When the 2005 guidance talks about "going further than the legislation" it does so by reference to "the provision of cessation advice and support to those who wish to quit smoking". It may not be attractive to contemplate but I infer 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. There are 8,000 prisoners, on average, in the Scottish prison system at any given time of whom I understand a very high proportion are likely to be smokers. The situation in England & Wales has been described as follows:

"... there was evidence and research demonstrating the feasibility of making mental health units smoke free, whereas there was no evidence or research to the same effect in the case of prisons. On the contrary, there was some evidence that applying the smoke free provisions to prisons in the short term would increase the risk of disorder and assaults and compliance would be difficult to achieve."

It is not just a question of numbers. Although I have no information, either generally or in relation to the petitioner, that seclusion, restraint and medication were used to enforce the smoking ban or to control aggressive behaviour that resulted, it is the case that patients in the State Hospital can be lawfully subjected to a range of physical and chemical constraints and restraints which are not generally available for controlling prisoners. It makes me uncomfortable to learn that compelling psychiatric patients to stop smoking was treated by the respondents as a research opportunity [*R (N) v Secretary of State for Health* [2009] HRLR 31, 927 at § 83 *per* Lord Clarke of Stone-cum-Ebony MR and Moses LJ; 7/9, "Smoking", report by medical director, 6; 7/17(39), minute of Smoking Cessation Task Force meeting 21 January 2011, § 3.11; 7/17(43), minute of Smoking Cessation Task Force meeting 21 April 2011, § 10].

[124] On the information available, I have come to the view, though with reluctance, that the decision to compel the petitioner to stop smoking was flawed in every possible way. In that it relied on compulsion, the decision was contrary to the national policy which it purported to implement. The decision should have been made with reference to the section 1 principles of the 2003 Act but was not, and was in contravention of the obligations imposed by section 1 on the respondents. The respondents did not, for example, take account of the petitioner's wishes, or provide him with the requisite information; and on no

reasonable view could they have reached the conclusion that the smoking ban, to the extent that it was necessary, was implemented in "the manner that involves the minimum restriction on the freedom of" the petitioner. Whether or not consultation is a legal requirement, if it is embarked on it must be carried out properly. I am satisfied that the compulsory "comprehensive smoke-free" regime was a foregone conclusion and that the consultation exercise was not a meaningful one [*L v Board of State Hospital* 2011 SLT 233 at §§ 6 and 24; *R v Brent London Borough Council Ex p Gunning* 84 LGR 168; *R v North and East Devon Health Authority Ex p Coughlan* [2001] QB 213].

[125] Counsel for the petitioner advanced a "process challenge" and a "reasons challenge" with reference to the *City of Edinburgh Council* and *Doody* cases founding on aspects of the failure to comply with section 1 principles, like failing to allow the petitioner to participate and failing to keep him informed: but I do not think that these add anything [*R v Secretary of State for the Home Department ex p Doody* [1994] 1 AC 531; *City of Edinburgh Council v Secretary of State for Scotland* 1998 SC (HL) 33].

[126] If article 8 ECHR is engaged, and I hold that it is, it is for the respondents to justify interfering with the petitioner's right to make his own decision about smoking. They have failed to do so satisfactorily. Indeed, I am satisfied that the decision to stop the petitioner smoking in the hospital grounds constituted interference with the petitioner's article 8 ECHR rights without lawful warrant — because it was not made in accordance with section 1 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 cigarette smoke.

[126] The respondents have also failed to demonstrate an "objective and reasonable justification" for treating the petitioner differently from adult, long-term prisoners, who can smoke if they wish. Going further, on the material presented to me and in the absence of any other suggestion, it appears that the only justification for imposing a smoking ban on mental health detainees like the petitioner and not on penal detainees is that it is feasible to compel mental health detainees to stop smoking because of their vulnerability. This is not a legitimate justification. Accordingly I hold that there has been a violation of the petitioner's right not to be discriminated against in the enjoyment of his article 8 ECHR rights contrary to article 14 ECHR. Reading between the lines, I infer that Scotland does not have a complete statutory prohibition on smoking in the buildings and grounds of psychiatric hospitals in general and of the State Hospital in particular because the government could not, at the time, gather the requisite consensus for such a ban. If the legislature will not support a measure it is wrong to enforce it by extra-statutory means. It may be of course, given the experience at the State Hospital, that the time is now right to try and put the ban on a statutory footing.

[127] The petitioner is claiming damages of £3,000 with interest as, it seems, "just satisfaction" for breach

of his Convention rights. Mr Leighton refers to the prison "slopping out" cases in support of the petitioner's claim. He also refers to two cases about compensation for injury to feelings for infringement of statutory rights. (My understanding is that Mr Leighton does not seek a distinct award in this case for non-compliance with section 1 of the 2003 Act.) I have no difficulty with the idea that the petitioner has been deprived of one of his few pleasures, that he dwells on his inability to smoke, that he feels frustrated and aggrieved, and so on. On the other hand, the unequivocal effect of all the information put before me is that the petitioner must have gained significant health benefits from not smoking. He must also have saved a lot of money. He claims to have, or to have had, a 40-a-day habit so that, on the figures suggested by counsel, he must have saved about £8,000 since the smoking ban came into effect. The orders that I propose to make will allow the petitioner's case to be reconsidered by the respondents. If he still wants to smoke in the hospital grounds, it may be, for all I know, that he will be allowed to do so. I agree with Mr Campbell QC that it is not appropriate to award damages in this case. I take the view that a finding of a breach of the petitioner's rights is appropriate satisfaction [*Greens Petitioner* 2011 SLT 549; *Vento v Chief Constable of West Yorkshire* [2003] ICR 318; *Da'Bell v National Society for the Prevention of Cruelty to Children (NSPCC)* [2010] IRLR 19].

Proposed orders

[128] The petitioner has ten pleas-in-law and the respondents have eight pleas-in-law. I propose to give effect to my decision by repelling all of the respondents' pleas, by repelling the petitioner's pleas numbers 1 to 6 inclusive, which are the pleas for setting aside the smoking ban and the prohibition of tobacco products, by repelling the petitioner's plea number 10 which is the plea for damages, by sustaining the petitioner's pleas 7, 8 and 9 inclusive, which are the pleas for declarator. I shall pronounce decree of declarator in restricted terms to the effect that the respondents' policy is unlawful insofar as it affects the petitioner and that the respondents' policy and decision are in breach of the petitioner's Convention rights articles 8 and 14 ECHR. I shall reserve all questions of expenses.