NOTE: HIGH COURT ORDER PROHIBITING PUBLICATION OF NAME OF APPELLANT REMAINS IN FORCE

IN THE SUPREME COURT OF NEW ZEALAND SC 60/2016

BETWEEN **B**

Appellant

AND **WAITEMATA DISTRICT HEALTH BOARD**

Respondent

ATTORNEY-GENERAL

Intervener

Hearing: 16 November 2016

Coram: William Young J
Glazebrook J
Arnold J
O'Regan J
Ellen France J

Appearances: R K Francois for the Appellant
J P Coates and P W Le Cren for the Respondent
P T Rishworth and P J Gunn for the Intervener

CIVIL APPEAL

MR FRANCOIS:

Counsel's name is Francois, I appear for the appellant.

WILLIAM YOUNG J:

Mr Francois, thank you.

MR COATES:

May it please the Court. Counsel's name is Coates appearing for the respondent District Health Board with Mr Le Cren.

WILLIAM YOUNG J:

Thank you Mr Coates.

MR RISHWORTH:

May it please the Court. Rishworth for the intervener with Mr Gunn.

WILLIAM YOUNG J:

Thank you Mr Rishworth. Have you, Mr Rishworth and Mr Gunn, agreed on how the second half of the hearing will be divided up?

MR RISHWORTH:

As between…

WILLIAM YOUNG J:

Yes.

MR RISHWORTH:

Yes, we have Your Honour. Would you like me to…

WILLIAM YOUNG J:

Yes, if you could.

MR RISHWORTH:

The thinking was that if there were two hours allocated for the two of us it would be provisionally one and a quarter for my friend and 45 minutes for me.

WILLIAM YOUNG J:

Thank you. Right, Mr Francois?

MR FRANCOIS:

Yes, may it please the Court. Your Honour, just a couple of preliminary points. I have this skeleton outline of the arguments for the appellant which I can forward to you. In addition, Your Honour, I've been asked by my learned friend for the respondent to just make a point about one of the affidavits that is in the appellant's bundle. It's in the case on appeal. It's the affidavit in the first volume, sorry, volume 2, of Mr Colin Watson. Now that affidavit was actually the subject of a ruling in the Court of Appeal in relation to fresh evidence. Strictly speaking it is not admissible in this Court. However, because the ruling, Your Honour, in the Court of Appeal was relevant, the affidavit was included as part of the case.

WILLIAM YOUNG J:

What page is it?

MR FRANCOIS:

We'll find that Your Honour in volume 2, it's the last affidavit.

WILLIAM YOUNG J:

I see, yes, thank you.

MR FRANCOIS:

It's the last affidavit, it's document 48. Now Your Honour I also have a short opening statement that I would like to make, and I have that too that I'd like to just hand up. This is approximately three to five minutes, no more.

WILLIAM YOUNG J:

Are you going to read it or distribute it?

O'REGAN J:

Mr Francois, can you move just a little bit closer to the microphone, I'm just having a bit of trouble hearing you.

MR FRANCOIS:

Sorry Your Honour.

WILLIAM YOUNG J:

Perhaps move the lectern a bit closer.

MR FRANCOIS:

I'm sure you'll hear me soon. So may it please the Court. This case is about human dignity, the backbone of our Bill of Rights. Your Honours, I'll make it clear. Forcing psychiatric patients into nicotine withdrawal is not humane, where confinement in intensive care depends upon an assessment of their behaviour, and nicotine withdrawal symptoms mirror the symptoms of their psychosis. The statutory framework, that's my client's point. It allows them to smoke on hospital grounds. An edict in a local council policy does not change the law. In a country where Government is by the consent of the governed, it must be limited in its power to act against the rights of its people. Prejudicial stays are caused by their addiction. Psychiatric patients carry a burden. The subject of a different type of discrimination. In a society that increasingly demands perfection from its citizens, the appellant belongs to a group that suffer from the burden of imperfection. A Government cannot do whatever it likes to them simply because of the virtue of the democratic mandate it has to enact the Crown Entities Act 2004, which the respondent relies upon. The protection of minorities is a necessary concern for all modern democracies. In a country that says it takes human rights seriously. I mean, really. The vindication of human rights must be a legitimate pursuit of all New Zealanders, regardless of their wealth. Regardless of their disability. Or the extent or a degree or acuity of it. The history of psychiatry shows that our Bill of Rights must act as a counterpoint to a legacy of prejudice and stigma and unequivocal acts of cruelty and torture. For what is our Bill of Rights? What has it got? If it cannot say the things it truly values, and

not the words that others mean, this Court stands tall as an innovator for the rights of all and once more, Your Honours, the appellant asks, into the depths of imagination. One cannot judge a nation by how it treats its highest citizens, but its lowest ones. Those who live with us are our brothers, and they share with us the short moment of life in this world that is dying, seeking what satisfaction and fulfilment they can. If we think no individual can change the lives of others, it was a young Polynesian who sailed across the Pacific Ocean and discovered a new world. A woman fought for a cause that established the first democracy in the world and it was a coloured man who broke down the barriers of apartheid and united a nation, and a man from Virginia declared all men are created equal. Created equal.

I now turn to the skeleton Your Honour. So the first point I've just covered really, is what is the case about. The second point is really the legal hook. This is what gives the right to begin with. The legal right, not the right under the Bill of Rights, but just the legal right, and that's the interpretation of section 6 of the Smoke-free Environments Act 1990. Of course, the difficulty is in the word "may" because the respondent says, well, it's only that the hospital may allow patients to smoke, depending on certain conditions present. That's the problem with vagueness, because of the modality of the verb "may", what does it mean, possibility, probability, or we can turn to its meaning in legal sense by certain cases, and one of the earliest is *Rex v Barlow* 2 Salk 609, 91 ER 516 from 1663 and then *Alderman Backwell* (1683) 1 Vern 152; followed by the *Reg v Tithe Commissioner's* (1852) 14 QB 459 case in 1852 where it was held that it's become an axiom that may means must, so the discretion becomes a duty, an obligation and that the person who holds that power must exercise it, and then further, that was elaborated further in *Julius v Lord Bishop of Oxford* (1880) 5 AC 214 (HL), where the Court held that the enabling powers becomes a duty when there isn't a legal right in the statute.

Now turning more recently to a High Court case in Australia, in *Finance Facilities Pty Ltd v Federal Commissioner of Taxation* [1971] 127 CLR 106. There it was held that again the word may became an imperative

because of the context of the words, and the circumstances that gave rise to an interpretation that may means must. And that actually was supported in this Court, and the Court of Appeal, in *Tyler v Attorney-General* [2000] NZLR 211 (CA) except it was just, it wasn't applied because it wasn't, the circumstances were different, the context was different, the provisions were more logical, it lent itself towards a discretion rather than an obligation or duty, but the important thing is that the President of the Court of Appeal at the time, President Richardson, Justice Richardson said, that it could be read down, but not on this occasion. And he actually, His Honour referred to *Finance Facilities*.

So now we turn to this particular section, section 6, and we apply it. Well we certainly have the word may –

WILLIAM YOUNG J:
Don't you really have to start with the scheme of this part of the Act? I mean I would have thought the starting point is section 5 which prohibits smoking in workplaces?

MR FRANCOIS:
Yes, yes.

WILLIAM YOUNG J:
From which section 6 operates –

MR FRANCOIS:
Section 6 is an exception, yes.

WILLIAM YOUNG J:
As an exception.

MR FRANCOIS:
Yes.

WILLIAM YOUNG J:

But is it an exception that, your argument is that it's an exception that the employer, in this case –

MR FRANCOIS:

Must apply.

WILLIAM YOUNG J:

Must apply.

MR FRANCOIS:

That's what I'm driving at. And Your Honour –

WILLIAM YOUNG J:

But apply is that only in relation to hospitals?

MR FRANCOIS:

Yes Your Honour. Specifically in relation to –

WILLIAM YOUNG J:

Sorry, I actually put that, didn't put that precisely. Only in respect of patients in hospitals?

MR FRANCOIS:

Perhaps, Your Honour, we should go to the section. We should look at the actual wording, would that be helpful? Which is in the bundle of authorities at para 5, this is the appellant's bundle of authorities, tab 5, and it's the section 6 dedicated smoking room, which is at, you see it at the second to last page, page 17. So in section 6(1), "An employer may permit smoking by patients or residents of a workplace that is, or is part of, a hospital care institution, a residential disability care institution, or a rest home if," and there we have the (a), (b), (c), (d), again these conditions or circumstances, which is what *Julius* was referring to, and the *Tithe Commissioners*, and indeed *Finance Facilities*, the High Court, the High Court of Australia was very keen on having a set of

circumstances listed before you can invoke or interpret the may as a must. And here we have a set of circumstances.

ARNOLD J:
The “may” in section 5 capital A is clearly discretionary, isn’t it?

MR FRANCOIS:
In –

ARNOLD J:
Because –

MR FRANCOIS:
Sorry Your Honour?

ARNOLD J:
In 5 capital A the use of the word “may” does not mean “must”. It deals with smoking in vehicles and it provides that employees, if they all agree, can request their employer, can ask their employer to permit smoking. It doesn’t indicate that the employer has to agree. They may simply request the employer.

MR FRANCOIS:
It is a slight, if we look at the text of section 5A, Your Honour, it is different. The listing of the circumstances are different. There is a way in section 5A to, if you like, to negate the discretion. There is very – there is an opportunity there. They identify a person who can do that but here in section 6, in section 6(1), as we go down we don’t really see a way that the discretion is not going to be fulfilled unless those conditions are met. If the conditions are met, the conditions are satisfied, the argument from the appellant is that it should be exercised, it must be exercised, the discretion must be exercised. And a major point about these provisions of course is the purpose, is the purpose of the Act, and the purpose of the Act is not to punish or to penalise people who are addicted to nicotine.

WILLIAM YOUNG J:

Well it is a bit. I mean if they can't, if they're addicted to nicotine and they work somewhere, well they won't be able to smoke while they work. So if you treat that as punishment, which I don't actually, then it does have that effect.

MR FRANCOIS:

That's, I accept that. In this context it's the fact that they're detained under an enactment and that's perhaps where it looks from their perspective, punishment.

WILLIAM YOUNG J:

People in a rest home aren't necessarily detained though.

MR FRANCOIS:

No, no.

GLAZEBROOK J:

Although they may –

WILLIAM YOUNG J:

They may be. They may practically be.

GLAZEBROOK J:

They may be and practically they may not be able to go out and stand outside.

MR FRANCOIS:

And there was, in the –

WILLIAM YOUNG J:

But some of them would be.

GLAZEBROOK J:

Yes, some of them.

MR FRANCOIS:

Yes, and in the Hansard debates there was mention about this, that it would not be humane to force the elderly who are very immobile to go out into a street and smoke cigarettes. So the point is not just the context of the provision but its purpose. And Your Honours, I might take you to Helen Clark's statement about – or I know we're just so short of time, I can take you to Helen Clark's statements in the Parliamentary record about this.

O'REGAN J:

Do you want to just give us the reference to it and we can look it up?

MR FRANCOIS:

Yes, I believe it's in this –

GLAZEBROOK J:

You've got a reference in your submissions, haven't you?

MR FRANCOIS:

Yes, Your Honour. I do like – I just like the power of the statement.

O'REGAN J:

Okay, well, that's…

MR FRANCOIS:

So that's in the bundle of authorities, appellant's bundle of authorities, volume 2, and it is tab 36. It's page 1634 of the actual Parliamentary record and you can see, if you move down to the heading, "Smoke-Free Environments Bill," "Rt Hon Helen Clark," and it's the second paragraph on that page where she says, "It is not a punitive Bill. It is not a Bill that outlaws smoking or penalises those who remain addicted to the drug or who just choose to smoke. It is a Bill that ensures that the rights of non-smokers also are recognised."

GLAZEBROOK J:
Sorry, I've actually lost where you are.

MR FRANCOIS:
Did I lose you, Your Honour?

GLAZEBROOK J:
Okay, that's fine, thank you.

MR FRANCOIS:
And I just would like to keep that in mind throughout the interpretation exercise because it's very relevant. From Helen Clark's statement, it is exactly what the appellant was saying. Now, of course, the appellant does have evidence of the fact that this is not humane, and I think this ties in with the Parliamentary record. We all know, well, those of us who may have smoked, that giving up is not easy and we can see even today that there are many people who have to have counselling, advice from certain Government organisations, to try and quit. They have numerous subsidised nicotine replacement therapies, and so on, and it doesn't always work, that's why they're there, and the argument from the appellant is it doesn't work, these nicotine replacement therapies and so on, is because of the strong cravings and the nicotine withdrawal symptoms that simply overpower the individual, and the individual finally succumbs and has to smoke a cigarette.

Now the respondent says that, well you really don't have a lot of evidence about that, and all these cases that the respondent refers to, such as *McCann v State Hospitals Board for Scotland* [2014] CSIH 71, *R (Countryside Alliance) v Attorney-General* [2007] UKHL 52, [2008] 1 AC 719, they never refer to any evidence either. But we do and that's the Cochrane Review. A very, very well recognised scientific research foundation with its own reputation around the world as independent, thorough, and it has gone through all nicotine replacement therapy products, and came to the conclusion that for a person who is not motivated, or less motivated, because, I'll say less motivated to quit, there's a 3% increase in the chance of quitting, the

likelihood of quitting, if they take nicotine replacement therapy. Now according to the Cochrane Review, people who are unmotivated, like a lot psychiatric patients, they don't want to quit. He doesn't take, the Cochrane Review doesn't take that as a genuine quit attempt, so it's not real. It's not a quit. You can't scientifically, you know, take that into account, they just take people who are really motivated, motivated and less than motivated, and you can see that in the affidavit, which I'll just take you to, Dr Burns attaches the Cochrane Review. Now I'll just take you to one paragraph of that affidavit, because that sums it all up.

GLAZEBROOK J:
Volume?

MR FRANCOIS:
Volume 2 Your Honour and it is page 295 of volume 2.

GLAZEBROOK J:
Which numbers?

MR FRANCOIS:
Volume 2, so this is the affidavit of Dr Robert Mark Burns, dated 23 January 2013. Now there is a lot of technical matters here, which haven't been refuted by the way, let's make that clear, but it's paragraph 6, which is very, very important.

GLAZEBROOK J:
We haven't got the report have we?

WILLIAM YOUNG J:
The report will be in volume 3.

GLAZEBROOK J:
The report seems to be in another volume.

MR FRANCOIS:

Oh, yes, the actual review, to look at that, you turn to volume 3, page 703.

GLAZEBROOK J:

Oh, you're just taking us to the affidavit are you?

MR FRANCOIS:

Volume 3, page 703.

O'REGAN J:

But you want to take us to the affidavit?

MR FRANCOIS:

I just want to take you to the affidavit. Your Honours can read the report which is extremely long and it takes a lot to digest, but what Dr Robert Burns has done is just really summarise the findings.

GLAZEBROOK J:

Okay.

MR FRANCOIS:

And I think that's all that I want at the moment just to refer to. Now it's at paragraph 6. So what actually is in paragraph 6? It is quite technical but at the end, the last sentence is what I really want Your Honours to look at is, "Put together, this means that the most motivated groups increase their quit rates from about 12% to about 19%," and then in brackets 12 multiplied by 1.6 which is the risk factor, "whereas the less motivated increase it from about 2% to about 3%," and then again in brackets 2.1 multiplied by the risk factor of 1.6, and then to conclude at paragraph 7, "It is therefore logical that people who do not wish to quit smoking," and that's who we're talking about, "but are prescribed NRT are likely to have a less than 3% chance of quitting." So this is a very important distinguishing factor, Your Honours, in relation to all the cases that have come before the Courts overseas which my friend relies upon

because they don't put that data, that very important relevant data, in front of them.

ELLEN FRANCE J:

Just in relation to that, Mr Francois, I note that in the *Rampton* decision [*R (E) v Nottinghamshire Healthcare NHS Trust*; *R (N) v Secretary of State for Health* [2009] EWCA Civ 795] the majority do refer to what they describe as powerful evidence that in the interests of public health a complete ban was justified. So there obviously was evidence, and they talk about evidence before the Divisional Court there. So I'm not sure you can say there wasn't any evidence because that suggests it may have been different.

MR FRANCOIS:

Well, I think what I'm saying is that there's not evidence about how ineffective nicotine replacement therapy. That's the point that the appellant is making, not that there was no evidence at all before the Courts about how – about what Your Honour's referring to. It's just in this – there's no evidence in *Rampton* about how ineffective NRT is in terms of the Cochrane Report. What they do do, and you might see it if you go to the appendices of *Rampton* is that they, yes, they do go through some research, and some of it's contradictory because they also put in research that is actually, it goes against the hospital in that case. But importantly, there's – I could actually take you to it if you like because there's enough there in the appendices.

ELLEN FRANCE J:

Well, just when you get to that. Your point, as I understand it, is ineffective if you're talking about trying to get someone to quit.

MR FRANCOIS:

Yep.

GLAZEBROOK J:

Can I just, as I understand the argument of the Board, it's not so much individual notions about particular mental health patients who are quitting, it's

the whole effect generally of having a smoke-free policy generally throughout the population and throughout the hospital population. So one without exceptions actually encourages more than having exceptions, the aim of having people quit smoking in a general sense. So what do you say to that?

MR FRANCOIS:

Well, the first thing we say to that is that there are, there's not just one purpose of the policy. One of the purposes is that which you just described, but another one, which is probably more important, is to make psychiatric patients quit smoking and our argument is, well that's not rational, because there's no rational connection between stopping psychiatric patients from smoking in an intensive care unit, and actually making them quit, because the evidence is they don't quit. In fact Prochaska's report, which again is attached to Dr Burns' affidavit, well Dr Burns refers to it in paragraph 8, but it's actually later attached and it's in the bundle of exhibits, but Prochaska found that in a study of United States mental hospitals, in many different hospitals, that of all the people who were confined in a smoke-free mental institution, every single one of them resumed smoking once they were discharged, or released from that unit. 100% failure. So that's the first point, Your Honour. So it's not rational in that regard. The second point is more towards what you're suggesting, and that is while, you know, this broader obligation to promote healthy lifestyles for everyone. Well you see we've always argued that that is disingenuous because they don't enforce the policy, and we've seen that with a number of affidavits. Robyn Berryman –

GLAZEBROOK J:

So what does that mean in terms of patients can smoke outside the grounds or –

MR FRANCOIS:

Yes, yes, they smoke on the grounds.

GLAZEBROOK J:

Sorry?

MR FRANCOIS:

They smoke on the grounds. They smoke five feet from the reception area and no one enforces it.

GLAZEBROOK J:

All right.

MR FRANCOIS:

So if it was really that important to promote these healthy lifestyles, then why don't they shun them all out. I mean, yes, the rule is that you must go outside to the roadside –

WILLIAM YOUNG J:

Probably not that easy to enforce as a matter of practicality. I mean there's no statutory sanction other than for the no smoking in the grounds policy I take it, other than the general entitlement of a property owner to control what happens on the property.

MR FRANCOIS:

Well you see, Your Honour, this is the whole problem with the policy, is that it's a break, it results in a breakdown of the therapeutic relationship –

WILLIAM YOUNG J:

No, you've gone slightly off the topic I was talking about. The prohibition of smoking within the hospital walls is governed by the Smoke-free Environments Act. Outside the hospital walls but on the grounds it's a matter for the Health Board as a property owner, I take it, is that right? Is there any other statutory sanction for the no smoking on the grounds policy? So as a matter of practicalities it's probably rather a hard policy to enforce.

MR FRANCOIS:

Not really.

WILLIAM YOUNG J:

What do you do, do you run out and sort of manhandle the people to the ground, or rip cigarettes from their hands, or what? Or prohibit them from going outside?

MR FRANCOIS:

Well, Your Honour, what you have to do is you have to go there and you have to see it, and when you see the environment where they are, it actually is quite easy. For example, Waiatarau. So Waiatarau they go out the back. They go out the – so there's a courtyard which is right next to the main doors of the unit, right there, and everybody just goes into the courtyard, there's nice seating there, and smokes. Now the nurses are five feet away. Doctors, five feet away. Now they could just say, put the cigarettes out. They could say, well that's the easiest way, put the cigarettes out. And if they said no well they would threaten them with ICU, that happens all the time, and we've seen it in the affidavits, we've seen it all in the affidavits, that's what I'm saying, is what the appellant is saying, is that it's punishment. You go to ICU to be punished because they know, all the nurses and the doctors and the staff, know, no one wants to go there because you can't smoke. So that's one of the problems. But in terms of enforcing it my argument is no, that's not hard it's simply a case of just saying, put it out. You have to see the unit, Your Honours, you have to see the units, the way they're fenced, or the way they're situated. The way they can be controlled. The way that the staff can visually see them. And of course now that Taharoto has changed it's, Taharoto these days was much different, was much different in terms of how staff could monitor patients who went outside because it was a little more difficult to actually monitor. But now, very easy. Very easy. They've really structured that and designed, because they've designed a big building, and it's modern, state of the art, very easy to control it, and it's a matter of saying put that cigarette out, and they follow instructions. If they don't, they're in trouble, and they know it.

Now Your Honours I also just want to make it clear that these, what the appellant's saying in terms of the nicotine withdrawal symptoms is that they

might seem to somebody who doesn't smoke as quite mild or quite trivial but they actually are quite recognised as very powerful mind-altering symptoms, and I can take Your Honours to the diagnostic and statistical manual of mental disorders in the exhibits because that's called the DSM-IV, but there's now a DSM-V, that's basically the psychiatry handbook and if lists all the symptoms of nicotine withdrawal so that Your Honours are aware that this is not something that we're just making, the appellant is making up, because it kind of is a bit of the inference that the psychiatrist for the respondent is saying to about my client and the other applicants. So Your Honours to turn to the DSM-IV we go to the exhibits and I believe it's in volume 3. No, sorry Your Honours, it's volume 4. No, no, this is terrible it is volume 3, it's page 664. And then 664 lists nicotine dependence, some facts there, then turn over the page again that's where we get into nicotine withdrawals at page 665, and then across the page is the diagnostic criteria for nicotine withdrawal, and then they list the signs, and then you have depressed mood as a first one. Insomnia, irritability, frustration or anger, anxiety. Anxiety is 4, 3 is irritability, difficulty concentrating, restlessness, decreased heart rate, increased appetite or weight gain. Now on top of that, in the DSM-V which I was hoping to photocopy for Your Honours as a supplementary, but I don't want to inundate you with more and more material, but headaches is another one. Now I mention that specifically because that's pain. Anybody who's experienced headaches knows that that's pain.

ELLEN FRANCE J:
In terms of the course of those symptoms, we have to look, don't we, at 668?

MR FRANCOIS:
666 to 668?

ELLEN FRANCE J:
It's 668.

MR FRANCOIS:
The course.

ELLEN FRANCE J:
That is how long those symptoms will last.

MR FRANCOIS:
Yes, yes, yes. That's very relevant because they – remember the stays in the ICU are generally not that long and with the symptoms that you're referring, with the course that you're referring to there, that's – they will sustain that for the entire period. Most people are only in there, well, certainly for less than four weeks. So they will endure that, for that entire in period.

But I do want Your Honours to appreciate the pain aspect because, again, it's not to trivialise but headaches is pain, and these are psychiatric patients who have done no wrong. They're not criminals. The last time pain was inflicted on a criminal in this country was the death penalty.

WILLIAM YOUNG J:
Can I just you sort of a peripheral question? How do policies around alcohol in hospitals correlate to policies around smoking?

MR FRANCOIS:
Yes –

WILLIAM YOUNG J:
Is drinking permitted?

MR FRANCOIS:
It's different in – it is different. The reason why alcohol, the way that the appellant distinguishes alcohol in the psychiatric unit and in cigarettes, like both of them are banned but one of them should not be, that's the cigarettes, is that alcohol is very disruptive in terms of its inhibiting effect.

WILLIAM YOUNG J:
So it's more immediate in its effect?

MR FRANCOIS:
Sorry?

WILLIAM YOUNG J:
It's immediate in its effect?

MR FRANCOIS:
It's immediate but it's the fact that it can cause a lot of managemental problems. It can create disruption, disorder. It can create inhibition in terms of sexual things, sexual matters.

WILLIAM YOUNG J:
Disinhibition?

MR FRANCOIS:
Sorry? Disinhibition, that's right. Especially, you know, there is that sexual thing which is a constant problem in psychiatric is to keep the male and female things separate. There –

WILLIAM YOUNG J:
I suspect, however, that you could have taken us to page under DSM-IV or V in relation to alcohol withdrawal that would have been perhaps corresponding, would have corresponded broadly to nicotine withdrawal.

MR FRANCOIS:
True, but, true, true but the distinction is that we, the appellant, does not advocate the use of alcohol in a psychiatric unit because it is so disruptive. Smoking cigarettes is not a disruptive –

WILLIAM YOUNG J:
All right. Okay, I understand.

MR FRANCOIS:
It doesn't create problems of that kind and it certainly isn't disinhibiting. It's not going to, for example, if somebody gets into a sexual relationship is not

going to regret it the next morning if they're smoking cigarettes but they certainly might if they get it, a mentally ill patient, if they're into, if they're getting involved in alcohol in the unit, and that's the – while we're on that topic, Your Honour, that's the same thing about pornography. We've heard this before from the respondent. Well, what's the difference with pornography? Why don't we have pornography in the mental unit? And again, it's different. As I've previously said, you have a male wing and a female wing, and a lot of the time the staff are trying to keep the sexual thing out of the way. They do not want these interactions.

WILLIAM YOUNG J:
Okay, no, I understand that.

MR FRANCOIS:
Now to put the pornography openly amongst all the, let's put it on the, into the lounge room, you know, this is not, again, smoking doesn't have this kind of effect. So they're just, the comparison is just not logical, it's not rational, there's reasons, there's good reasons for banning pornography and good reasons for banning alcohol.

Now Your Honours, back to the skeleton. I think we've moved down to about, because I know we're short for time, so I think we've moved down to about five, I think we've progressed pretty – now there is one point at five I would just like to, yes, five is probably where we're at. Now this again is to reinforce the "may" means "must" argument, but to go into another statute, and that's the Crown Entities Act, because the argument from the appellant is that the Crown Entities Act does not actually assist the respondent in this case. firstly, because if "may" means "must" then the Crown Entities Act can't override section 6 because of the obligation, because of the requirement in section 19 of the Crown Entities Act which says this Act can't be, you can't do anything that's inconsistent or contrary to another Act. So that's if "may" means "must". So that's if the discretion is actually more than just an enabling power by the jury.

Now what I've said there in addition to that is a slightly different argument, is that well okay, let's accept the respondent's view that it is a discretion so that "may" means "may". This is where we say well now we're getting into a redundancy issue because under the Crown Entities Act the Crown can do whatever it likes with its hospital grounds and its buildings. Then we go to section 6 of the Smoke-free Environments Act and it says the same thing, if we take the respondent's interpretation. It can do whatever it likes with its buildings. You don't have to have a smoking room if you don't want one. So then –

GLAZEBROOK J:
But it doesn't quite do the same thing, does it, because section 6 provides an exception from the workplaces, smoke-free workplaces legislation, so that provides it for everybody effectively whether a private operator or the State or a Crown owned enterprise, as long as they come within the section 6 entities that are able to provide that exception.

MR FRANCOIS:
Yes, it's true Your Honour. The point is not something that the appellant is relying heavily on. It's just that when we look at some of these cases, they do get into these double discretions, like *Julius* or [inaudible] as I've mentioned here where the provision has two discretions and the Court says, well, how can that be right. The first one says "may" and the second one says "may" and so they say well the first one is "must" because otherwise it's redundant to have two, these double discretions, and so I would refer Your Honours to [inaudible] but you can also see it in the reasoning in *Julius* because they are – there's a similar point that comes out in the – there's two discretions. So that's all I'm saying there and not relying heavily on it but it does seem somewhat strange that why didn't the Crown Entities Act just simply repeat section 6 or make some sort of note because it is a later statute.

But moving on, Your Honours, because all of this is about uncertainty as to what these words mean, and that's at number 6, or what does "may" mean. Now if there is uncertainty, so Your Honours are unsure if it is a "must", what

do we do? Well, this is where the appellant says, well, if there is ambiguity or uncertainty in the meaning of words then we've got to take into account the Bill of Rights and we have to look at interpreting it consistently with the Bill of Rights and that's, as Your Honours well know, lots of questions on that. And then on top of that we say even if it's unambiguous that "may" means "may" then we say, well, you should still interpret it consistently with the Bill of Rights to promote the rights of patients because it's not going to be inconsistent with the statutory framework and that's where we rely on *Ministry of Transport v Noort Police v Curran* [1992] 3 NZLR 260 (CA) one of the first, 1992 case, one of the first Bill of Rights cases, where there was a very unambiguous word really for, the word "forthwith", very unambiguous. But it was interpreted as meaning "possibly 20 minutes" so that a person could have the right to consult a lawyer at the roadside. So the "forthwith" became 20 minutes. Now they said that because, well, it's not really inconsistent with the statutory framework of the Transport Act, and that's what I'm saying here. So even if it is a "may", even if, let's have a look at the rights of the patients and say, "Well, look, is it really that inconsistent with the rest of the statutes? The Mental Health Act, the Crown Entities Act, and so on?

Now, of course, we say that the blanket ban, like all blanket bans, there's always going to be an injustice to somebody and this is one of them, it's psychiatric patients, and that's because it's inhumane to them in terms of what it does, and that's section 23(5) of the Bill of Rights. Section 23(5) of the Bill of Rights all about humanity and dignity.

So what are the features of this inhumanity? Well, as we say, you've got to look at the context, the vulnerability of these patients. They're in this institution. They've been detained. They've been taken out of their homes. Probably lost their jobs. They're in a time of crisis in their lives. Their coping skills are very low and here they are, thrown into nicotine withdrawal. So what does this cause them? Well, it causes pain if they headaches, causes anxiety, increased anxiety, anger, insomnia, and so on. But the real problem is that they're the most acutely unwell. So the less acutely unwell don't go through this. It's the most afflicted, and that alarms me because there are

alternatives. That's the whole thing. There are less restricted means. In the intensive care unit, you have a giant cage outside, like a giant bird cage if you like, and they just walk out, and it's got a little shelter but it's all caged up and it's outside. And if you stand more than two metres away from a person who's smoking, the science says, and I'll turn Your Honours to it, you have got no chance of having any carcinogenic effect from second-hand smoke. Two metres. Now that's not hard to enforce when you look at these giant cages. Very big cages and there's pictures of them, pictures of them in the exhibits. You'll be able to see those. And, once again, right next to the nurses. They can just say, "Look," of course, everybody who goes out there smoking, 80% of psychiatric patients smoke, I mean, and that's in the DSM-IV as well. So – and when I referred Your Honours to that material, you can just read that, you'll see it's 80%. Well, that's one of the assessments. It can be higher. So most people who go outside in the cages in the ICU go out there and smoke. But if you had somebody out there who doesn't smoke, all they have to do is enforce the two-metre rule, stand six feet away. What about the people inside, like the staff? Well, they're not going to be affected because they're going to be six feet away.

Now I'll take you to Klepeis because that's the Stanford –

WILLIAM YOUNG J:
Sorry, take us to what, sorry?

MR FRANCOIS:
That's the – it's the Stanford Research, Your Honour. I just think we should go there because, again, we're not making this up. Now, Your Honour, you'll find that in the exhibits at, yes, it's at volume 4, page 1138.

ARNOLD J:
What was the page number?

MR FRANCOIS:
1138.

ARNOLD J:

Thank you.

MR FRANCOIS:

Now, Your Honour, it is entitled *Real-Time Measurement of Outdoor Tobacco Smoke Particles*, very – it's Stanford University. A lot of data, a lot of technical information. I'm not going to take you through this. Your Honours are welcome to read it. What I will take you to is the point that I was just making about the two metres. Now –

GLAZEBROOK J:

It seems to be from a single cigarette, it says in the abstract.

MR FRANCOIS:

Sorry?

GLAZEBROOK J:

That says from a single cigarette. Is that…

MR FRANCOIS:

Yes, that –

GLAZEBROOK J:

Because presumably they're not going to be single cigarettes that we're looking at here, are we?

MR FRANCOIS:

Well, I think when we look at the situation of the caged environment it'll be a – one person will be smoking a cigarette. Another person will be next to them smoking a cigarette. Where does the other person who's not – it's purely hypothetical. So what you're saying, Your Honours, what happens when another patient comes along who's a non-smoker, goes out into the –

GLAZEBROOK J:

No, I was really asking if you've got 10 cigarettes two metres away, is that different from one cigarette two metres away?

MR FRANCOIS:

I'm not so sure, Your Honour. Perhaps if we turn to the point. Look, if we go to page 1151, and then probably more if we look at the summary conclusions. Anyway, page 1151, it's the second paragraph. Now OTS, can you, second dot point, or it actually becomes the first dot point, or second paragraph at the top, can you see that, where it starts, "OTS levels."

GLAZEBROOK J:

Yes.

MR FRANCOIS:

OTS levels are highly dependent on source proximities. Levels at 0.25 to 0.5 metres can drop by half or more at this distance, increased to one to two metres. Now this is the point. At distances larger than two metres levels near single cigarettes were generally close to background, and that was it. Now background. What, background means, that's anything. That's like if you go out to the street, that's background. That's carbon monoxide.

ARNOLD J:

I think the answer to Justice Glazebrook's point is in the last paragraph.

GLAZEBROOK J:

Although it's not entirely clear what that means I have to say.

MR FRANCOIS:

Yes, look –

GLAZEBROOK J:

I think it just means there's very much more higher levels, which is what you'd expect, but it doesn't say much about the greater than two metres does it? Because there's also this whole downwind and wind factor.

MR FRANCOIS:

Yes, the wind factor is definitely, if it's downwind then okay the two metres is probably going to have to be extended. But if it's going the other way then you could actually shorten the two metres. So what you have to take into account is that you have to look at the cage, and when you look at the cages there's not a lot of wind because they're very sheltered. So I think the wind factor may not be so critical with the ICU units, or the – that I'm talking about, but nevertheless the fact, what surprised me here, and probably would have surprised some people, is that just because you can smell smoke, doesn't mean you're going to be actually affected by it.

GLAZEBROOK J:

Can I just, you can't rely on the "may" means "must" for your outdoor argument, can you? Or I suppose you could to the extent you'd say well this is a viable alternative to providing what might be expensive and inconvenient such as a room with ventilation. Is that the argument or what–

MR FRANCOIS:

It's an interesting point because I, you have to go through these conditions, the circumstances where the "may" means "must" and in section 6 it has to be a ventilated, one of the conditions is a mechanical ventilation, and I think there we just go into purpose because what's the purpose of that provision in that subsection, or that condition or precedent if you like in section 6. It's all about the most effective ventilation, and we're saying well that obviously outdoor ventilation is far more efficient than a mechanical ventilator in a room. So that is going to be, that condition is going to be satisfied with the outdoor cage. Then you might say, well it's not really a room is it, and it's not, is it a room? Does it have four walls? No, it doesn't, but we know that rooms under the Smoke-free Environments Act don't have to have four walls to be a room and

to be outdoor. In this occasion we're saying well we haven't got four walls, but we do have a roof and we do have one wall, and that's always the wall that you walk out of, the doors that you walk out of, of the unit, and then you've got either a circular sort of cage, or you've got cage, like that, so there's definitely three ventilated alls, and then you'll have some sort of roof. It will be either glass, caged, but then under the cage there's a sort of like an awning, some sort of roof material, that sort of thing, so we would argue –

GLAZEBROOK J:
Well in short you could say it could be seen –

MR FRANCOIS:
It could be a room, yes, yes. So the short answer is, well actually, yes, Your Honour, we do rely on "may" needs "must" for the outdoor, the cage exception.

Now Your Honours, I'm turning down to point number 8. So we are –

ELLEN FRANCE J:
Just on that point, "workplace" is defined as the internal area, isn't it? So how does that work when you're talking about the outdoor cage?

GLAZEBROOK J:
I think there might be an argument that the Ministry or whoever enforces this is having with public houses on this in terms of whether those, the outdoor areas are truly outdoors so it might be – and I think that's what you're referring to, isn't it, here?

MR FRANCOIS:
Yes. That's true.

GLAZEBROOK J:
I mean, I'm not sure where that argument has got to but it has certainly been an argument, hasn't it, that –

MR FRANCOIS:

Yes, it has.

GLAZEBROOK J:

– that these sort of things attach to public houses or are not in fact truly outdoors and therefore not within it but –

MR FRANCOIS:

Yes –

WILLIAM YOUNG J:

Is there a photograph of one in the material?

MR FRANCOIS:

Of the cage?

WILLIAM YOUNG J:

Yes.

MR FRANCOIS:

Yes, there is, yes.

GLAZEBROOK J:

I mean, I'm not entirely sure where that argument has got to. I just know that there are arguments on that.

MR FRANCOIS:

So to go and to have a look at some of the photographs, Your Honours, it's attached to one of Dr Patton's affidavits. It's at volume 4, page 1103.

GLAZEBROOK J:

That might be volume – no, it's…

MR FRANCOIS:

Now that's the Waitarau cage. It's not a great photo. It's not entirely clear but you can get a reasonable…

WILLIAM YOUNG J:

So what are the vertical walls made of or the vertical – are they glass or…

MR FRANCOIS:

Yes, it's an interesting one. I think they're different. One of them, do you see here, that's what it is, they're different. The ones up the top, how you've got area A, those are definitely glass. Now – because that's –

GLAZEBROOK J:

Sorry, where? I can't quite see area A.

MR FRANCOIS:

Area, see –

GLAZEBROOK J:

No, no, I see area A. I'm just not sure what's definitely glass.

MR FRANCOIS:

The two – the vertical – sorry, did you say vertical or…

WILLIAM YOUNG J:

Yes, the vertical panel.

MR FRANCOIS:

Of the vertical? No, they're walls. They're walls. They're concrete walls.

GLAZEBROOK J:

They're what, sorry?

WILLIAM YOUNG J:

On the left of one, it, you can look through it. It's…

MR FRANCOIS:

But that is not the actual cage that we, I was referring to. That – the cage that I was referring to is actually area B but the cage that the – what you're seeing at area A, that is the – it's attached to intensive care unit and it's – but it's another sort of outdoor area. It's – and if you turn to Dr Patton's affidavit, he describes what these things are.

GLAZEBROOK J:

So where do we find that? Under volume 2?

MR FRANCOIS:

Yes, yes, you can find – if you go to Dr Patton's affidavit where he describes these at volume 2, page 315's for area A. So volume 2, page 315.

GLAZEBROOK J:

315 did you say?

MR FRANCOIS:

Yes Your Honour.

GLAZEBROOK J:

So that's marked L, so that's – the patio is likely to be deemed substantially closer and therefore an internal space, that's the answer to one of the questions.

MR FRANCOIS:

Yes, that, I'm not, yes, I'm not relying on –

GLAZEBROOK J:

No, no, that was just a, that seems to be the answer to one of the questions that was asked.

MR FRANCOIS:

Yes. Now in terms of the area B area which is the giant cage he says, he refers to that, Dr Patton refers to that, at external areas… actually I think it's, yes –

GLAZEBROOK J:

Somebody else was talking about those cages and areas which I've now lost sorry.

MR FRANCOIS:

Yes, 1103 is – 1102, okay. Yes, that's Taharoto isn't it. Anyway. Area B, Your Honour, is definitely Waiatarau and if we go to area B in the left-hand picture, the left-hand corner, that is the cage at Waiatarau. So they walk out from the unit and that is the cage that I'm referring to. So you can see total ventilation all three sides.

WILLIAM YOUNG J:

Sorry, what page?

MR FRANCOIS:

We're back to 1103.

WILLIAM YOUNG J:

1103?

MR FRANCOIS:

1003, back to the exhibits, the photographs.

O'REGAN J:

Those walls are a cage material there?

MR FRANCOIS:

They're cage material.

O'REGAN J:

They're hurricane wire or something like that?

MR FRANCOIS:

Yes, that is wire, that is wire.

WILLIAM YOUNG J:

But it's two sides of, is it two sides of hurricane wire or three?

MR FRANCOIS:

That one is three, that's wire. At area B, left-hand corner –

WILLIAM YOUNG J:

Yes, okay, there are three sides.

MR FRANCOIS:

Yes, three sides of wire. I've been in it. Not as a prisoner.

WILLIAM YOUNG J:

Okay, what about, so they obviously, these areas obviously are not all the same, some are more enclosed than others?

MR FRANCOIS:

Yes, look, you're right, you are right. The, I believe the one at Taharoto, because remember Taharoto, if we go back a page, that's all different now. Just one page back is those photos there. Now Taharoto is, because it's a new unit now, those cage, the caged areas there are no longer in place. But it was replaced by something exactly, or almost identical to area B, left-hand corner.

GLAZEBROOK J:

Do we have dimensions? For the two metre issue do we have the dimensions of these anywhere?

MR FRANCOIS:

These are big. Well that one there is huge, that area B left, I don't have the dimensions Your Honour, no I don't I'm afraid, but they are, I guess it's hard to tell by the photo but they are quite, that's a big one, area B, left-hand corner. Because that's taken from the road, there's a driveway really, through the bushes to the back of the unit.

WILLIAM YOUNG J:

So where are you now?

MR FRANCOIS:

We might have to resume later.

COURT ADJOURNS: 11.30 AM

COURT RESUMES: 11.49 AM

WILLIAM YOUNG J:

Right, Mr Francois.

MR FRANCOIS:

May it please Your Honours. In terms of the outline, I believe we're up to paragraph 8, which again is dealing with the section 23(5) Bill of Rights argument. As you know, there really is two arguments here. One is – the first one at 7 is whether it's humane or not and then at 8 we look at the argument that there's two limbs to section 23(5) which is perhaps somewhat more controversial.

So what the appellant is saying is that the dignity limb is all about personal autonomy. The first limb, humanity, is about, obviously, things that concern the humane treatment of a patient.

GLAZEBROOK J:

Can you please again just pull the microphone up a bit? Thank you. Your voice was just disappearing slightly for me.

MR FRANCOIS:

It'll probably build up, Your Honour. So just to – so the dignity limb is different to the humanity limb.

WILLIAM YOUNG J:

Well, does it make any difference? I mean, I perhaps would have been inclined to read them together but I'm not sure that it makes any difference.

MR FRANCOIS:

Well, that appears to be my learned friend's argument for the Attorney-General is that they're really the same thing, or maybe not the Attorney-General so much but certainly that was the argument from the Court below. And the Court below did refer to Article 10 of the ICCPR in which there is a very similar provision which states must be treated with humanity and with respect to the dignity of the human person as opposed to, I think, as in our case, the person, and they said there, well, according to the International Covenant on Civil and Political Rights reference that was because different languages may not appreciate humanity or the meaning of humanity, so they included dignity as well.

I don't – yes.

WILLIAM YOUNG J:

Does it make any difference?

MR FRANCOIS:

To me, well, to – for our argument, it actually – for our argument, the appellant's argument, it is important because for our argument dignity is very much about choice.

WILLIAM YOUNG J:

About?

MR FRANCOIS:
Choice.

WILLIAM YOUNG J:
Choice.

MR FRANCOIS:
About decisions, yes. It's about decisions that affect a person's autonomy and that is a bit different from just saying what is humane and what is not. Dignity, we say, is different. It is different. It's – and there is a –

WILLIAM YOUNG J:
Okay. No, I understand that. I understand that.

MR FRANCOIS:
Yes, Your Honour. Sorry, Your Honour. So what we say is that by denying the patients the opportunity to smoke a cigarette, which they do at work, you know, every day, when they're outside of the hospital, they're denied a choice or a decision that affects their autonomy. It's an autonomous decision and it's one that affects their dignity, being told they can't do it when they ordinarily do because they like it. There's many reasons why they do. Makes them feel better, makes them relaxed, whatever. That a decision that should be respected.

Now what my learned friend is concerned about, or both the respondent and the intervener, is that, well, if you're protecting every decision then it's far too broad. But that's not the argument. This is why we get into the two limbs is because we say well no it's not every decision, it's only those that impact upon, or are accompanying matters of humanity. So you have a decision and then it results in some sort of inhumane result. That's what we're focusing on. When you're detained of course it has to be when you're confined, the State confines you then you want to make a decision, it's not every decision, it's only those that result in some sort of degradation, some sort of anxiety, or

some sort of pain, distress, discomfort, that sort of thing, if it's inhumane. That really is the argument.

WILLIAM YOUNG J:

Is the current policy in relation to prisoners a breach of section 23(5)?

MR FRANCOIS:

In my submission it is. Remember in that case Justice Brewer said that the State, that forcing prisoners into nicotine withdrawal is not humane. That was his finding, and there was evidence about that before him, including affidavits from certain prisoners.

WILLIAM YOUNG J:

I've got the sequence of events, well I haven't got them clearly in my mind. When was the statute changed? Was it after Justice Brewer's decision?

MR FRANCOIS:

Yes, after Justice – sorry, no, no, Your Honour, it was actually changed before, yes, it was before. It was after Justice Gilbert's decision and before he made it there was also an amendment but after the decision came out with Justice Gilbert, then it was changed. So yes, most definitely. It's a similar argument because in that case people were committing suicide and we had a, you know, we had an affidavit in that case from Mr Tony Adamson who lost several litres of blood and was rushed off to hospital and he testified that, you know, this was due to the fact, you know, he was in a state of distress and because he couldn't smoke and try and sort of calm himself down, you know, he went to these extra lengths. Just thought there was no hope. People do these things and of course you can see the psychiatric patients who have taken their lives because they can't smoke. You can see that with *In the Matter of Blair Calvin Edwards* CSU-2010-CCH-00609, S Johnson, 23 November 2012 there's the Coroners' report in which Mr Edwards frequently was under a compulsive treatment order at Hillmorton, and then they introduced a smoke-free policy, like every District Health Board, and he just said to his mother that, you know, he'd sort of lost hope of ever,

you know, wanting to go back there, and she was convinced that, you know, this was going to be the end because he wouldn't seek any treatment and that subsequently committed suicide, and she testified in front of the Coroner and said she believed that that smoking was the be all and end all for him, and she said to the Coroner that, you know, she just thought when they introduced that policy and he started complaining about it, that, you know, he wasn't ever going to go back, and he'd have to really make it work this time.

WILLIAM YOUNG J:

I think you better move on. So you've dealt with that.

MR FRANCOIS:

Yes, Your Honour, so in terms of prisoners and psychiatric patients there definitely is relevance between the two, and the provisions are actually also relevant. Section 6A was mandatory, that was the prisoner one, that was a mandatory, that wasn't a "may", it was a "must". But bear in mind that was in relation to formulating a policy, that was a policy, you had to have a smoke-free environment policy and they said they must have one because it was, they were smoking internally, there wasn't any designated room, you know, so that's the reason why it's different in the sense that they must have a policy rather than they must provide a smoking room. I – the appellant's submission is that they're both, they've both been the same. Must. And if they didn't then there's also one line of argument is, well, why didn't Government repeal section 6 which allows smoking in designated rooms in mental health hospitals when they repealed section 6A for prisons?

ELLEN FRANCE J:

But in terms of 6A, it was implicit in or was apparent on the face of the wording that there would be smoking, wasn't it?

MR FRANCOIS:

It was very –

ELLEN FRANCE J:
Because otherwise you wouldn't have to talk about not putting smoking and non-smoking prisoners together.

MR FRANCOIS:
Yes, it was very specific, yes. It was a lot – the provisions were worded differently. You're absolutely right, Your Honour, but I think the purpose is the same, is that they're allowing it, and in a mandatory way, not a discretionary way.

Well, look, I think, yes, so we do rely on the prisoner cases and definitely bear in mind it's slightly different provision but same purpose, same objective.

Now, well, so look, Your Honours, I think I will move on because I only really have 25 minutes left, which is a shame but that's all I have. So I will move onto number 9 in the outline, and this is the argument that the policy is discriminatory and we say that because it's the most acutely unwell who are afflicted with this nicotine withdrawal symptoms, the prejudicial stays because of the way they behave because they can't smoke. It's misinterpreted as part of their psychoses. It means that they're detained longer but their counterparts, the less acutely unwell psychiatric patients in the open ward who don't have the cage and stuff, they don't go through this at all. So they don't – they're not subjected to this type of effect, this impact, this detrimental impact. So –

ARNOLD J:
Just let me understand. People are in the ICU for relatively short periods of time and during that time they will have access to nicotine replacement –

MR FRANCOIS:
Therapy.

ARNOLD J:
– which should alleviate some of the problems in the short-term.

MR FRANCOIS:

You see, this is the –

ARNOLD J:

In other words, it may not be a successful strategy for giving up smoking but it will alleviate some of the withdrawal symptoms for a while.

MR FRANCOIS:

See, this is the argument, this is the difficulty, because the appellant says no, it doesn't alleviate. Now what my friends say is what you're suggesting is that, well, it might not be effective in terms of making you quit but it certainly reduces the, you know, impact of these, you know, negative symptoms. We say that's not true and we point to our evidence. We point to, we point to the Cochrane Review because if it was so effective, if it's effective then you wouldn't have the work team withdrawal symptoms. You see, it's the symptoms that drive you not to quit. You can't quit because you give up. It's too strong. It's overpowering. You see the point is it's the same thing to say, when we say, this is ineffective, 3%, 3% quit rate. We say, well, that's the same as saying, "These people suck." They suffer very strong and negative nicotine withdrawal symptoms.

WILLIAM YOUNG J:

Sorry, what's the best evidence that people who get nicotine withdrawal treatment nonetheless suffer from nicotine withdrawal symptoms?

MR FRANCOIS:

Well, of course –

WILLIAM YOUNG J:

Is there any specific evidence on that?

MR FRANCOIS:

Well, we have got – well, it's the – I guess again it's the craving that drives them to smoke and that means the quit attempt fails. So it's the craving, it's the – you see, if you didn't have the nicotine withdrawal symptoms –

WILLIAM YOUNG J:

I know, but rather than list a view of it, is there some evidence that nicotine withdrawal treatment doesn't work to relieve the symptoms of nicotine withdrawal?

MR FRANCOIS:

Well, Your Honours –

WILLIAM YOUNG J:

I mean, I imagine there is but –

MR FRANCOIS:

There – we've certainly got all the applicants.

WILLIAM YOUNG J:

Okay, so the applicant say –

MR FRANCOIS:

We've got all the – well, you've seen, you can see in, I mean, their evidence how they suffered.

WILLIAM YOUNG J:

All right.

MR FRANCOIS:

You know, you can read copious amounts and I can read some to you.

WILLIAM YOUNG J:

No, no, I understand what they say. But it –

MR FRANCOIS:

But they're suffering even with the NRT. It's terrible. Now on top of that we do have the evidence of a psychiatrist, a couple of psychiatrists, in fact. Dr – down at – one of the psychiatrists down in Hillmorton who wrote a very good affidavit on behalf of the appellant. He referred to the breakdown in the therapeutic relationship between the nurses and the patients because the patients continually abused and were angry at the nurses for not allowing them to smoke. Now they were on NRT. Why would they do that? Do you think that the NRT, is it curing their nicotine withdrawal symptoms so they go and abuse the nurse? You see, if it's not, if it's curing, their nicotine withdrawal symptoms, if they're not feeling the negative stuff, then why, why get angry? Why get agitated? Why take desperate measures such as sticking a lighter inside your body so that you can have a cigarette in the ICU? Is it because the NRT is really just having a great effect on the cravings? This is – and you can read applicant C, what happened to her, where she was so desperate for a cigarette in ICU that she hid a lighter in her vagina. Now the respondent says, "Oh, well, you know, she was just insane and that's just her psychoses." But she didn't walk around in the open with a lighter up her vagina, did she? This is degrading. And we also hear from Nurse Jenny –

ELLEN FRANCE J:

Sorry, who was the psychiatrist who was talking –

MR FRANCOIS:

Sorry, yes, Dr – I'll turn Your Honour –

ELLEN FRANCE J:

If you just give me the name.

MR FRANCOIS:

Dr James Adams. He's at volume 2 and he's – his evidence is at page 500. Now he also does mention about the ineffectiveness of nicotine withdrawal, I mean nicotine replacement therapy. But also is Nurse Steele, Nurse Steele in

her evidence, her account of the fact that patients suffer terribly, even when they're one nicotine replacement therapy. Remember if 90% of this population who smoke, of those who smoke, want to quit and you have nicotine replacement therapy available, why is that so many people do continue to smoke? Well, again, you see, it goes back to the fact that it's the withdrawal symptoms that take over while they're trying to quit. It's those cravings and all the agitation, the anger and all the other things that go with it, that drive them to this, but in this context it's appalling because we're trying to cure them of the problems in their head and you're just making it worse.

So anyway, just to finish this point, I just want to make it clear that what we're doing in terms of this discrimination argument is we're comparing two groups because they're actually in the same ground of disability. They're – the same mental illness group or mental disability, but one is more severe or acute than the other group, and so we call this the intra-grounds argument. It can equally be called adverse impact discrimination. But that's – it's a slightly different type of discrimination. We're not comparing it to another group of patients, not another like general patients. It's within the group of mental disability. Very acute, they suffer. Less acute, they don't.

That is basically the argument. That's the thrust of it. Now you will hear from the respondent so I'll probably just cover that in closing about who was the comparator group here, who was the – the who comparator, and we say that ours is logical, ours is a –

WILLIAM YOUNG J:
Sorry, you say, sorry, who?

MR FRANCOIS:
We say our group is logical. It's a very logical comparator group. I'll let my friend talk to you about who he thinks the comparator group should be and then I'll respond.

WILLIAM YOUNG J:

Okay.

MR FRANCOIS:

Now moving on to paragraph 10, Your Honours. This can really be in a nutshell, this is the section 9 argument. Ordinarily one would say, well, there's no way that you can make a case of degrading or disproportionately severe treatment or torture but the appellant says it all depends on the context and *Taunoa v Attorney-General* [2007] NZSC 70, [2008] 1 NZLR 429 goes into that. These are very vulnerable people. They're at a time of crisis in their lives and the state, who is supposed to be looking after them, is intentionally, and that's the word, intentionally inflicting harm, and that's where the appellant argues that this falls into section 9 because of the intent. And in terms of the harm, as I pointed out, the headaches, and I can get a photocopy of the DSM-V which, because that's updated from the DSM-IV, which lists headaches as pain, as one of the side – one of the factors, number 4 in the list now.

GLAZEBROOK J:

But what do you say about the long-term health effects of smoking? Obviously a short-term, 10-day enforced withdrawal perhaps doesn't have a major effect on those long-term health benefits but that's a slight difficulty in terms of the torture. Is it, "Will you please let me carry on with something that in the long-term is very, very bad for me because I have some relatively unpleasant, and especially when added to my mental illness, but not life-threatening"?

MR FRANCOIS:

Yes, interesting. Interesting, yes. Well, I – there's some case law in Canada about having a pre-existing disadvantage and then lumping something else on top of it and that's the way I see this is that they already are in a state of disadvantage and you're making it worse. Now I don't know if that quite answers your question, Your Honour. Can you just elaborate?

GLAZEBROOK J:

Well, I was just saying that in terms of saying, well there are these short-term issues, in fact smoking creates these long-term, very dangerous issues. Now obviously, as I said, it's not going to necessarily be alleviated by just a 10 or 15-day abstinence but it does become slightly tricky. I can understand it in terms of a right to decide to kill yourself if you want to but it's difficult to say it's torture when someone tries to stop you killing yourself, isn't it?

MR FRANCOIS:

Yes, well, look –

GLAZEBROOK J:

Even if that attempt may not be successful.

MR FRANCOIS:

Yes, yes. Your Honour, I don't perhaps – the appellant's argument is not so much the torture, it's disproportionately severe treatment which comes under section 9 but it doesn't have to be a focus –

GLAZEBROOK J:

I'm sorry, I was using torture as the generic term.

MR FRANCOIS:

Right, yes, well, you see, it serves no purpose to inflict this harm or suffering on these patients because they're not going to quit. The evidence is they don't. Prochaska, in the material, his research, or her research, Dr Judith Prochaska. And so the effect that this has even though two weeks is not going to improve their health, of course, it's de minimis. They stop smoking for two weeks or three weeks, so what? It's not going to improve anything. And when they start up again, you know, what was that all about? Why did I go through that? And now I don't want to go back to that hospital ever again. And so people are, like 35% in another study in Canada, refused to seek treatment any more, and that's a telling – that's another very – that's a report by Kurdyak and that's in the materials. Very important.

And Dr Tim Dare refers to that report in Canada, 35% of patients are no longer seeking treatment because they don't want to go to a smoke-free hospital.

In terms of the suicide, well, of course, there is a responsibility in the United Kingdom and the UK Supreme Court has decided that the right to life includes a psychiatric patient being looked after in a mental institution and being prevented from killing himself. They must take, I think the words were something like reasonable – if they have reasonable knowledge that the person is suicidal then they are liable for a breach of the right to life.

Now, of course, as Your Honours know, there's three suicides here. One of them we couldn't get the case into this Court. The Court of Appeal refused to have the evidence heard, but it's well known. Another case was that of *In the Matter of Shawn Paul Cowley* CSU 2012 HAM 000545, 8 August 2013 P Ryan, who went out for a cigarette and jumped off the hospital carpark, top building, top floor. Then we have a murder. They allowed a patient to go out for a cigarette. She said, "Well, I'm going to go and kill my next-door neighbour," and she did.

So the case raises a lot of safety issues as well. You'll hear from my friend about that because he says, well, it doesn't really happen at his, his client's premises. I'm not so sure about that. Very hard to get information from this respondent.

Your Honours, I think that covers number 10. So now we're down to number 11. So we're really almost there. Now this is the right to private life argument or home life, recognised in the UK and Europe but not recognised here. Not yet. Well, certainly not the Court of Appeal. The Court of Appeal did not recognise it. Now the reason why the Court of Appeal didn't is because –

WILLIAM YOUNG J:
It's not in the Bill of Rights.

MR FRANCOIS:

Sorry?

WILLIAM YOUNG J:

Because it's not in the Bill of Rights.

MR FRANCOIS:

Yes, that's why she's – well, because it's not an existing right, I think was the more – because remember under the Bill of Rights, this is the argument, under our Bill of Rights, section 28, section 28 says it doesn't have to be a right in the Bill of Rights to be a right that's protected. That's quite important. I'm paraphrasing. Now, of course, it's not a right in the Bill of Rights but as Justice Tipping said in *Brooker v Police* [2007] NZSC 30, [2007] 3 NZLR 91, it doesn't have to be necessarily an existing right. It's the value that's important. The underlying value. And this is where the appellant says, "Well, look, as we move into a society that is continuously having their rights or their privacy rights subjected to surveillance or other means, other invasive means, is that can't there be a right to home life, that those things that we value in our home lives, our personal lives, can't they be protected? And I think that's a very important issue and one that just can't be dismissed by saying, well, it's not in an existing right, when you look at what Justice Tipping was referring to. The values are important and dignity, remembering that dignity is the backbone of our Bill of Rights from the opening statement. It's all about dignity, and home life, private life, is about that.

Now Your Honours are not going to be impressed because perhaps smoking is just not the case to be arguing here about a right to home life, but that doesn't mean there's not a right to home life. I think the second is, well, is it triggered? If there is a right to home life, which the appellant says there is, then is there, is smoking cigarettes, is that a right to home life even though you're in a public institution, which is, of course, is his home for all, even the respondent acknowledges, it is when you're in a psychiatric institution and you're detained, it is your home, just like a prison is, and there's lots of the Parliamentary records refer to that. It's your home.

So first of all, is there a right to home life? We say yes. Second of all, well, is smoking one of those things? Well, that's a harder one. We accept that. But still we refer to the *Rampton* case, of the, importantly, the dissent in there but distinguishing from *Rampton*, I'll only be a minute, distinguishing from *Rampton* and the *McCann* case, which my friend is going to refer to, remember they were forensic units, the criminally insane, high security. What we're dealing with is in the open ward, well there's no secret, you know, it's open, come and go. In the ICU, low at best, in terms of the Department of Corrections standards. Low. That's – now *Rampton* had a big issue about constant supervision of these patients. So it was very hard to get them out to smoke, bring them back in, you've got staff resources and so on. Very difficult to manage a smoking regime in that environment. Different here. Just different here. It's easier. And of course remembering the importance of the dissent in *Rampton*. Look at the dissent Your Honours because you'll see some really good arguments that the appellant submits are completely on point, when he goes into why smoking is so important to certain people.

Well look Your Honours I'm just going to make the final point and then let my colleagues, my learned friends take over. The last point is the consultation argument. We have, there's a lot of evidence here. But none of it shows that they consulted with psychiatric patients. Yes, they consulted with staff. Yes, they consulted with psychiatrists, nurses, some organisations, but in terms of actual patients, no consultation.

ELLEN FRANCE J:
In relation to that, when Jocelyn Peach is talking about consultation with, she talks about consultation with mental health consumers –

MR FRANCOIS:
Yes.

ELLEN FRANCE J:
And then with consumer representatives, are they not patients?

MR FRANCOIS:

Look, the problem – yes Your Honour. The problem with Jocelyn Peach's affidavit is that it was about the Mason Clinic. Now the Mason Clinic is a forensic unit. It's high security.

ELLEN FRANCE J:

Well I didn't read her overview of the smoke-free history policy as dealing only with the Mason Clinic but I might be wrong about that.

MR FRANCOIS:

It's certainly, I'm sure my friend will correct me if I'm wrong, but it was the Mason Clinic. Now if counsel is wrong on that, the consumer representative, that was a staff member. Now that was a staff member. I think her name was, oh, [inaudible]. We don't have a lot of evidence of what she discussed, in fact there's no evidence about what she did, what Karen [inaudible] did in terms of discussing with psychiatric patients. So she was the consumer representative, again a staff member. The psychiatric patients, there was going to be a person, a person who was going to be like an appointed representative for, not a staff member, but an actual patient, to represent the patients and consult with them. But if you go through the evidence, the exhibits, and I will if I have to in the reply, is that it's all TBA. Like you read the minutes. You read the minutes of the board meetings, you know, there's representative, patient representative, TBA. He's never named.

GLAZEBROOK J:

What do you say the effect of non-consultation, because fairly obviously it's only going to be consultation with the people, and possibly not with somebody who's in ICU currently because one imagines that they'd be probably too unwell to be bothered. I don't mean, I mean to be inconvenienced even further by consultation.

MR FRANCOIS:

Well, you know, the thing is, Your Honour –

GLAZEBROOK J:

So it's not going to be the current plaintiffs, in others words.

MR FRANCOIS:

Well, not necessarily, you see with the ICU situation is that there's a lot of in and out.

GLAZEBROOK J:

No, no, I understand that. All I'm saying is it will be consultation with somebody who has just been in ICU rather than someone who's actually in ICU.

MR FRANCOIS:

Yes, probably. Probably.

GLAZEBROOK J:

But not the current plaintiffs because the policy will already have been in place.

MR FRANCOIS:

That's true. Well, that's –

GLAZEBROOK J:

So what's the effect of consultation? Why would you…

MR FRANCOIS:

Well, it's a lot to do with fairness, transparency and the right to be heard, you know, the –

GLAZEBROOK J:

It's just – and so – but does it invalidate?

MR FRANCOIS:

Well, is it inconsequential? I don't know. I don't know. I mean, maybe they would have come up with some of these points. I mean, maybe they would

have said, look, this NRT doesn't work, or, I've tried it. It's useless. Look, it's really not fair. It does this to me. You know, I don't know. It's hard to say. It's really hard to –

GLAZEBROOK J:
So this is a process point too.

MR FRANCOIS:
Yes, yes.

GLAZEBROOK J:
About a process. But you say a process point that could have had implications in terms of modification of the policy?

MR FRANCOIS:
In – yes, in terms of sort judicial review aspect, I mean, yes, it could've. But look, I think I'll leave it there, Your Honours.

WILLIAM YOUNG J:
Thank you, Mr Francois. Mr Coates.

MR COATES:
Your Honours, as Mr Rishworth has said we've provisionally divided up the allotted two hours by me having an hour and a quarter. That depends a little bit on what the Court indicates it may wish to hear from counsel on but certainly I've got – I'd like to take Your Honours through the narrative looking at the policy and so forth.

I'd like to start if I may with just a brief summary and make, I'd like to make five preliminary points all of which are referred to in the written submission, but if I just make them here in summary form.

First and foremost, this is an administrative law case and I think it's very important that we remember that. It's about a District Health Board, a

statutory decision maker, setting policies for the proper and effective management of its hospitals. The DHB, of course, has its empowering legislation in New Zealand Public Health and Disability Act 2000 which directs it to focus on protecting and promoting health. We say that the Courts must be slow to interfere with a policy decision made by a DHB utilising its own expertise, the doctors, the nurses, senior managers, the elected governors. This Court, in my submission, should be slow to interfere with the merits of a policy made by a statutory body such as the District Health Board. So that's the first point.

Secondly, and having said that, we say that there is considerable justification for the policy. The evidence is clear. There are around 5000 New Zealanders die each year from smoking-related illness. Three hundred to four hundred people die in New Zealand each year from exposure to second-hand smoke, passive smoking, and the evidence is clear that ventilation systems do not prevent the harm that can be caused by passive smoking. Smoking is particularly common amongst those with mental illness. The evidence that the District Health Board has put before the Court suggests around twice as many people with mental disorder smoke. My friend suggested that 80% of people today, he's suggested that maybe up to 80% of people are smoking, which is higher than the evidence that the District Health Board has put forward, but certainly the evidence is overwhelming that –

GLAZEBROOK J:
I thought that was schizophrenic patients, based on one of the affidavits, but I'm not sure.

MR COATES:
Well look, I understood it to be referring to people with mental illness generically, but certainly the evidence that's put forward on behalf of the DHB, which I think is pretty consistent, is that those with mental illness are heavily overrepresented as smokers. We know tobacco consumption has been steadily decreasing in the wider population, but not so in the mental health community. The problem isn't just about smoke related harm and direct

exposure to second-hand smoke. It's also been about the culture of smoking in mental health units. There's a lot of evidence before the Court, in particular from Associate Professor Sharon Lawn on this where she talks about tobacco culture in mental health has become, or has been deeply imbedded with cigarettes handed out on the hour, tobacco cigarettes used as a mode of control, and so forth. So that has been a significant problem.

We know from the evidence that smoking bans have, around the world, have shown to have a raft of positive effects. We know that there has been net reduction in smoking, less exposure to second-hand smoke, it's enhanced clinical care and so forth. We know from the evidence that partial smoking bans, partial bans, are less successful than complete bans. We know that around the world now smoking bans in mental health are becoming, mental health services, are becoming commonplace and we can see that in the cases that have come before the Court internationally. We've seen it in Scotland, the *McCann* case, we've seen it in the UK, with the *Rampton* hospital case, we've seen it in Australia with the *De Bruyn v Victorian Institute of Forensic Mental Health* [2016] VSC 111 case, and it's clear that smoking bans are becoming commonplace around the world.

So my third point relates to the change in societal attitudes to smoking over the last 20 years, and I think it's clear that there has been a profound change in attitudes to smoking, reflected in the legislative changes, dating back to the original Smoke-free Environment Act in 1990. My friend took you to the Honourable Helen Clark's speech, which actually came from the original 1990 Act. There was a, clearly, a very significant change when the relevant part of the smoke-free legislation was effectively rewritten in 2003 with the amendments. But even at a social level I think it's noteworthy that it wasn't so long ago that it was quite acceptable to smoke in other people's houses. It was acceptable to smoke in the workplace, and those things have really changed. The original Smoke-free Environments Act talked about smoking in half the staffroom. You could smoke in half the staffroom but not the other half, and really it's clear how far we've come since then. And we say, obviously, that the DHB's policy is entirely consistent with that, and we note,

and I'll come to this in a little more detail in a moment, we see the DHB's policy being developed over a 10-year period. This was not a hastily rushed decision, it was incrementally developed as society changes progressed over a 10 year period. And clearly making the point, I'm going to take the Court to the policy in a moment, the policy itself is now, of course, seven years old, so it's been in place for a considerable amount of time.

So my fourth point in my summary is that whichever way you look at it Mr B's plan, what he seeks is a right to smoke. What he wants to be able to do, and if he gets taken back, if he needs to back to the Mental Health Service at Waitemata DHB, he wants to be able to smoke in the facilities. Now while he attempts to categorise that, has a right to do, what he might be able to do at home, at liberty to do at home, or if he dresses it up as a discrimination claim, ultimately all roads, in my submission, lead to this being a claim by him that he has a right to smoke and we say that that simply is not the case. It doesn't, it isn't supported by any of the authorities, and it certainly doesn't have the hallmarks of a right that has been recognised by Parliament in the New Zealand Bill of Rights Act 1990 and has any of the qualities that this Court might look to when recognising a further right in accordance with section 28 of the Bill of Rights Act.

And we say, I say as my fifth point in summary, the rights-based issues cannot be divorced from the factual context in which they arise, and what that means here is that this is a case about Mr B as a mental health patient in the units, or even if we broaden that out to any patient in the mental health units, and we have to be cognisant of, first, Mr B's specific circumstances and, secondly, the necessary, obviously necessary rules that must be enforced or must be made to ensure the proper and effective management of a mental health service.

So just looking briefly at Mr B himself. We know that he spent around 11 and a half weeks in the adult mental health unit out of which he spent 10 days in the acute ICU unit, one period of nine days and then shorter periods and so forth, and so, in my submission, that's highly relevant to all the claims and

allegations that he makes. Now we know that he, like a number of patients who present for treatment, compulsory treatment, for a mental disorder, he had a number of comorbidities. He had type-one diabetes which required admission to the general hospital during his time in the Mental Health Service and like all patients he was provided and offered with nicotine replacement therapy and other means to alleviate his nicotine withdrawals, and we simply say that the suggestion that one might give a man such as Mr B nicotine in the most addictive form of cigarettes, the most harmful form of cigarettes, just simply doesn't make sense in a health institution. He was given nicotine in a different form. Quite clearly, in my submission, if he was an alcohol you would never think of giving him alcohol to treat his alcoholism. He was given nicotine to treat his nicotine withdrawal symptoms and –

ARNOLD J:
Is there any material in the case about the withdrawal, the replacement therapies easing the craving for nicotine?

MR COATES:
Yes, there is, and if Your Honour's happy to wait till I get to that point in the evidence, I'll draw your particular attention to it.

ARNOLD J:
Thank you.

MR COATES:
There certainly is evidence on that. So, look, we just – we say that my friend's categorisation of this case as forcing patients into nicotine withdrawal is just simply not an accurate way of describing it. The DHB is not forcing patients into nicotine withdrawal. We're simply saying when you are on our premises you need to comply by the rules and one of those rules is that you can't smoke. We will make sure that you have nicotine available to alleviate your symptoms because we recognise that that –

WILLIAM YOUNG J:

But this is just semantics though, isn't it? I mean, that you were saying to someone who is a chronic smoker, "Well, you can't smoke so you're either going to have nicotine withdrawal symptoms or you can take the medication we offer you"?

MR COATES:

Look, we certainly, yes, recognise they have, they've got limited choice. We recognise that it's going to be hard for them not smoking and we say that we will make available to you. We're not forcing it on them. We can't do that.

GLAZEBROOK J:

Well, no.

WILLIAM YOUNG J:

Well, I think you are actually. I think – I don't think it's particularly – I think it's rather a glib submission.

MR COATES:

Well, in my submission –

GLAZEBROOK J:

Well, you either have really horrible symptoms or you take this medication. It's Clayton's choice, is what's being put to you.

MR COATES:

Yes, well, I accept that. I mean, it's never been categorised by my friend as forcing medical treatment. You know, there is obviously the right in the Bill of Rights Act to refuse medical treatment and the DHB will always respect that. If a patient says they don't want to receive nicotine replacement therapy, we're not going to say, well, we'll force it.

WILLIAM YOUNG J:

Yes. No, I understand that. You're giving them a choice but it's a choice which they may regard as unpalatable.

MR COATES:

Yes, indeed. I accept that. So look, with those summary points in mind, really what I'd like to do is take the Court to the policy which, in my submission, is the obvious place to really start, and it's in bundle 3 at page 647. Volume 3, page 647. Now there are a few points I'd like to emphasise in here. I won't take you through it line by line but I would like to just emphasise a few points. You'll see at 647 on the left-hand side, half way down the page it describes the scope, and Your Honours will be aware of this, but I just draw your attention to it, that this applies to all individuals using the DHB's premises. Staff, patients, visitors, contractors, volunteers. So we're not just talking about mental health patients clearly we're talking about everyone.

ELLEN FRANCE J:

Could I just check, the policy changes over time, doesn't it, so what's the date of, this one is as at?

MR COATES:

Yes, so this one's in November 2009. At the bottom left you'll see in rather small font you'll see it says, "Date reviewed November 2009," do you see that?

ELLEN FRANCE J:

Yes.

MR COATES:

And, Ma'am, this is the policy that is the subject of the challenge. The previous policy, which I don't need to take you to –

ELLEN FRANCE J:

Is the 2006 or –

MR COATES:

2005 and then 2006. Now the material difference is that there was an exception in those earlier policies that allowed smoking in designated rooms in mental health. I'll touch on that a bit more as I go.

GLAZEBROOK J:

What's being put against you is not that it applies to everybody but it's that these people have no choice but to be there.

MR COATES:

Yes. No, I understand that.

GLAZEBROOK J:

So it doesn't help to say well it applies to everybody who's free to come and go, especially visitors who can be there for a relatively short time, for instance.

MR COATES:

Yes, well, and look, within all of these categories is referred to in the scope. Obviously people will be there for longer or shorter times and will have freedom to leave or not. The evidence is clear there are a number of people in the medical wards in the hospital who will be there for a reasonably lengthy period of time who also won't be able to leave to smoke, and I'll spend a moment, I'm shortly describing the Mason Clinic where people are actually detained for a very considerable periods of time and can't leave to smoke. So I will come back to that.

Just at the top of the next page, which is page 648 and the second page of the policy it talks there about the DHBs being required to ensure that employees, patients and members of the public are protected from tobacco smoke, and talks about its responsibility to encourage and support patients and staff not to smoke. You know, these are the broad high level statements we'll see in due course it's consistent with the statutory responsibilities of the DHBs. Then we see the actual key statement there, all DHB sites are smoke-free. No smoking is permitted anywhere inside the buildings and staff,

patients and visitors may not smoke in external areas. They must leave the site if they wish to smoke. So in my submission what this is, is an activity ban, it's a ban on the activity of smoking, or what might be called a where and when ban. When you're on, when you're on the DHB site, you can't smoke.

WILLIAM YOUNG J:
What would staff, I mean if there's a visitor smoking in the grounds, well they can be trespassed off?

MR COATES:
Yes.

WILLIAM YOUNG J:
If it's an employee who's smoking, they can be disciplined under the employment arrangement.

MR COATES:
Yes.

WILLIAM YOUNG J:
What do you do with a patient who smokes on the ground? You can't trespass that patient off.

MR COATES:
Well, look, I accept, and Your Honour indicated earlier that it's not without its challenge in enforcing the policy, you know, from time to time.

WILLIAM YOUNG J:
Mr Francois' suggestion was, well, they're just told that if they don't stop smoking they'll be locked up in the ICU.

MR COATES:
Clearly we don't accept that that's' the case. We're talking here about the mental health patients. We don't accept that that's the case at all. Look –

WILLIAM YOUNG J:

But how can you control the way mental health patients smoke in the grounds of a unit? I mean how can they be prevented from smoking in the grounds of the unit?

MR COATES:

Well, look, I mean in the extreme situation I guess you could call the security guard and say, "Look, you know, you're not allowed to smoke here. You've been given adequate warning. We are going to remove the cigarettes off you." Now I'm not sure, I can't tell the Court whether that's happening in practice. I'm sure it would be a last resort and –

WILLIAM YOUNG J:

I wonder what the legal right to do that would be?

GLAZEBROOK J:

Maybe assault, yes.

MR COATES:

Well, ultimately the DHB has the right, in my submission, to make the rules around what happens on its premises.

GLAZEBROOK J:

Well, it might, but does it have the right to assault people by taking their cigarettes off them?

MR COATES:

Well, the next point I was going to make in relation to this policy is that it's not actually a ban on possession of cigarettes. It doesn't ban that, and unlike actually some of the –

GLAZEBROOK J:

No, no, but you just said you could get the security guards to take the cigarettes off them. I would have thought you can't do that without touching them. That must be an assault.

MR COATES:

Well, look, it would obviously be very fact specific but, you know, it may well be that a particular scenario, factual scenario, might arise where the patient's been given adequate warning and continued flagrant disregard, it may well be, in my submission, that it would be justifiable to remove the cigarettes and the same –

WILLIAM YOUNG J:

By reference to what?

MR COATES:

Well, by reference to, I guess, ultimately –

WILLIAM YOUNG J:

I mean, normally if you don't like what someone is doing on your land you boot them off but, I mean, that's not an option in the situation you're postulating. You don't normally, are not normally entitled to say, "I'm going to physically restrain you," or –

MR COATES:

Well, in my submission ultimately you can if we're talking about now the acute mental health patients who simply can't leave in the same way if they have dangerous items it's –

WILLIAM YOUNG J:

So maybe it comes down to saying, "We'll put you in the ICU."

MR COATES:

Well, whether we say we're putting them in the ICU, we're going to say, "Look, it's simply not safe for you to have a cigarette lighter. It's simply not safe for you to have a knife. It's simply not safe for you to have a belt." And we are therefore going to exercise, what may ultimately be in my submission, a common law right to say that we're justified, given all the steps that we've taken to get to this point, we're justified in saying, "We are going to remove that from you."

ELLEN FRANCE J:

Well, if you look at what the policy says on the next page, that deals with patients, patient and visitor non-compliance, and that seems to suggest a trespass notice as an option.

MR COATES:

Yes. Well, that's right. The problem with the trespass notice, of course, is that –

ELLEN FRANCE J:

I understand that. I'm just saying that the trespass and discussion with the patient seem to be the options that the policy envisages being followed in that situation that you're being asked about.

MR COATES:

Yes. This, of course, being a general policy applying to the whole hospital rather than simply mental health, but, you know, in my submission, well, what is clear is that in addition to this general policy within mental health there are a number of other policies, as you would expect, that relate to the management of behavioural problems and ultimately in a mental health context, whether it's utilising some of the specific powers under the mental health legislation or more general common law powers, the mental health, health professionals are going to be – it's going to be appropriate and indeed in some situations no doubt would be their duty to intervene to prevent harm.

So, look, just turning over to the next page on the policy or perhaps just 650, I'll just make the point there around the health promotion and education, and health promotion being a strong focus of the DHB's vision. I think that this is important, in my submission, as well as promoting smoke-free throughout the DHB, information on smoking cessation and smoking change will be made available by all services for patients and staff. And then it refers there to some of the steps, and I'll take you to another document shortly, but some of the steps relating to the proactive offering of support to staff and patients, which is an important part of the DHB's response and recognition that this is a policy that does have real consequences to the patients.

So from that point what I'd like to do is just describe, perhaps just in the next five minutes, for the Court, exactly the nature of the facilities of the DHB in the Mental Health Service, and I'm at paragraph 7 of my written submission in doing this, and I can be relatively brief but I think there are a few important points to make.

Much of my friend's argument and indeed the evidence, focuses on to the Taharoto unit and the Waiatarau unit. Now these are the two adult inpatient units. There are a number of other relevant mental health facilities as well. The most clear example, in my submission, being the Mason Clinic, which is the forensic clinic and point, Carrington in Point Chevalier where there's 108 beds. Now the patients in the Mason Clinic are unlike in the adult units. They tend to come through the criminal justice system, through orders made under the Criminal Procedure (Mentally Impaired Persons) Act 2003, or they've got an intellectual disability under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, legislation. This is all referred to in the written submission. But importantly in the Mason Clinic those patients are often detained for very considerable lengths of time. These are patients who may be being assessed as to their fitness to plead, or it may be that they're found not guilty by reasons of insanity and so forth, and they can spend very considerable lengths of time in the Mason Clinic, I think ultimately even up to 10 years. Now obviously they can't smoke. They can't leave the Mason premises to smoke, and they're in the same position as the

people in the adult units are, and indeed obviously the same as those in the general hospital, and I think this is an important point for a number of reasons, including my friend who focuses so much on acuity of illness as being a defining feature as to whether you can smoke or not depending on which part of the adult unit you're in, but those in the Mason Clinic are not being detained based on acuity of illness. They're being detained largely because the underlying sentence or criminal justice process that they're subject to, and in my submission it's important that that's understood, and it's not as simple as just saying we're talking about the open side in the ICU. But then within those adult units, as my friend said, and the Court will understand, there are these ICUs, intensive care units, where people are moved and, look, you know, as I think –

GLAZEBROOK J:
What was the point about the Mason Clinic?

MR COATES:
Well the point about the Mason Clinic –

GLAZEBROOK J:
Because if your friend's right about the adult units then he must be right, in spades, about the Mason Clinic, isn't he?

MR COATES:
Well in large part it relates to the discrimination argument, it's more general than that, but his argument is that you're in the ICU unit because of the acuity of your illness, and if you've got a high acuity illness then you can't smoke, you can't, because you're stuck in the ICU, and that then becomes this intra-grounds discrimination, acuity of illness –

GLAZEBROOK J:
I'm not, to be honest I'm not particularly interested in the discrimination argument. I'm interested in the detention argument.

WILLIAM YOUNG J:

I suppose the Mason Clinic is a bit more like a prison, people are going to be there for longer.

MR COATES:

Well it is, exactly. And obviously they can't smoke when they're in prison. If my friend is correct then they should be allowed to smoke when they are in the Mason Clinic, so they come from the prison to the Mason Clinic –

GLAZEBROOK J:

Well they come because they're ill, though, not because they're being punished.

WILLIAM YOUNG J:

No, but what I'm, they may be there for a lengthy period of time if they've been – if they're a special patient, they're not guilty on a ground of insanity on a charge of murder, they're going to be in the Mason Clinic for years presumably.

MR COATES:

10 years, yes. Indeed.

WILLIAM YOUNG J:

Can I just ask you something, which I would like you to think about over lunch and come back to me after lunch. In relation to section, the humane and dignified treatment of those in custody, is this really an administrative law case or is this not a situation where we have to form our own view as to, as it were, de novo whether this is a humane and – policy that complies with the requirements of the statute, or the Bill of Rights?

MR COATES:

Well I'm very happy to address you about that.

WILLIAM YOUNG J:

Yes, I mean I'm not interested so much in the evidence of it. I'm just, the question of approach, is it sufficient for us to say, well, there's scope for different opinions but the Health Board has come up with a view which isn't obviously wrong and that's fine, or do we ourselves have to say we think it's a humane, or we don't think it's a humane policy?

MR COATES:

Yes.

COURT ADJOURNS: 1.00 PM

COURT RESUMES: 2.01 PM

WILLIAM YOUNG J:

I asked you a question before lunch.

MR COATES:

Yes, indeed, indeed, and, Sir, my answer to it is this, that in my submission ultimately the Court does need to form its own view as to whether there's a clear breach of –

WILLIAM YOUNG J:

What about a breach but only just?

MR COATES:

Well, my qualification on it was going to be it has to be in the context of what, or in this case, of a DHB making a statutory decision under its enabling legislation and also relevantly here the DHB saying that provision of nicotine replacement therapy is a reasonable and humane way of responding to the nicotine withdrawals and –

WILLIAM YOUNG J:

All right, well, what I'm interested is whether we look at it through the prism of the issue as primary for the DHB and we're reviewing it or whether we look at

in terms of whether we've just go to start afresh and if we think it's inhumane we say so even though we accept that the contrary view is a reasonable one.

MR COATES:

Well, I think, in my submission the administrative law basis for the legality of the policy and the rights basis of the arguments are inherently interrelated and they can't be totally separated out and so the Court, in my submission, does need to look at the consideration of, say, a breach of rights 23(5) in that whole context of the way the DHB made the decision, and it may, look, if the Court looked at it and said, "No, there are different ways of looking at it," in my submission that – the Court should be deferring to the DHB to the extent that the DHB has made its own decisions about the humane way in which it should be responding to nicotine.

WILLIAM YOUNG J:

So is there a case on this? You said *Osmond*.

MR COATES:

I said what, sorry?

WILLIAM YOUNG J:

Is there a case on this? Is *Osmond* a case you…

MR COATES:

Well, I'm not sure whether absolutely on that point in terms of deference and the extent to which the Courts look hard as part of its rights-based analysis, Justice Tipping in *R v Hansen* [2007] 3 NZLR 1, [2007] NZSC 7 talked about the scale of analysis and review and deference and in my submission that's likely to offer the Court considerable assistance on this point. I stand to be corrected but I don't think the Court, and I know three of Your Honours presided in the *Attorney General v Udompun* [2005] 3 NZLR 204 (CA) case. I don't think this was addressed in any detail the extent to which the Court –

WILLIAM YOUNG J:

Oh, yes. Okay, thank you.

MR COATES:

But certainly in my submission, and I think Justice Tipping's analysis might have expressly been more in relation to the section 5 proportionality analysis but in my submission there are broadly, the approach that His Honour took there as to the intensity of the law is highly relevant here. But, as I say, in my submission, certainly the Court are not experts in the treatment of nicotine dependency obviously so there will be a significant amount of deference in terms of the reasonable response to people who are suffering nicotine withdrawal.

Before I just return to the chronology, I'd just like to come back briefly, if I may, to some questions that I was asked about the enforceability of the policy, and I'd just like to say this briefly in addition to what I've already said. I think first and foremost the policy is about sending a very clear and strong signal that the DHB is not prepared to allow smoking taking place on its property for the reasons that we've talked about, and the fact that there may or may not be in any particular case difficulties with enforceability in my submission really doesn't take matters too much further. Certainly it doesn't, in my submission, in any way or can't be in any way viewed as a means for questioning the legality of the policy itself. In the same way, the fact that there may be difficulties sometimes enforcing an alcohol policy doesn't mean that the underlying integrity or legality of that policy is called into question.

But secondly, I think, and I did make this point a bit earlier in a slightly different way perhaps but, you know, non-compliance with the policy is managed first and foremost in accordance with good clinical practice and that's a patient-specific analysis for the health professionals determining the appropriate way to manage it and with a patient who is in the open side of the ward that will invariably mean they are escorted to the boundaries of the property, if it's safe and appropriate for them to do so, at which point they can obviously do what they want. And ICU, and the situation is a little bit different

because obviously they can't be escorted, but there is a specific policy, and I'd like to take the Court to it, which relates to removal of items where it's necessary for safety reasons in the ICU and it includes cigarettes. So if I just briefly take Your Honours to that. It's in volume 5. Volume 5, page 1792, and you'll see that this is a service user property storage policy for the mental health acute adult units generally, but then you'll see half way down that first page under the subheading "Property Service User", you'll see that it then talks about the intensive care unit and it says, "This procedure needs to be read in conjunction with the unit's ICU guidelines," and then you'll see the second point there near the bottom of the page under "Action", "The service user is asked to hand over all potentially dangerous property, including belts, shoe laces, cigarettes, lighters and matches, sharp objects and weapons," and then over the page you'll see it talks about return of such property.

So the practical reality is that patients in the ICU will not, certainly if the policy has been complied with, have cigarettes and lighters. I'm told that the threshold for intervention and removing cigarette lighters, other items such as that for safety reasons, will be high and it will be linked to the need to intervene for safety reasons. I'm told, and I say this from the bar, that it's only occurred to the best of the knowledge of those I've consulted in the lunchtime on one occasion where there was a genuine fire risk. People were concerned about a genuine fire risk and someone had locked themselves into a room and they went in and removed the lighter and the cigarette. But the threshold is going to be high for that type of intervention.

So at that note if I – unless Your Honours have any further questions on those points, I'll take you back to my written submission, and I'd just like to spend a moment, I'm at paragraph 10 of the written submission, page 3, paragraph 10, just explaining in a high-level way really the development of the policy. It's very well set out, in my submission, in the evidence, but there are a couple of key points that I'd just like to make and, look, the chronology, I think the story, in my submission, starts in 2000 with the Minister of Health issuing the New Zealand Health Strategy and I'd like to take the Court to that document

because I think that's an important document which really sets the scene. So this is the best part of a decade before the ultimate policy is introduced.

GLAZEBROOK J:
Is this a current strategy or has it been replaced?

MR COATES:
Look…

GLAZEBROOK J:
It doesn't really matter. It's just –

MR COATES:
I think the answer has to be it would have been replaced. It was the Labour Government coming in in 2000 and introducing their new strategy and as I talk I recall the National Government introducing better, sooner, more convenient, their policy, I think. So I think it has to have been replaced. But it's important, in my submission, to the story here and it's at volume 6, page 1838, and if I just take you – I'll just draw Your Honours' attention to a couple of key points. First in the introduction the Honourable Annette King.

GLAZEBROOK J:
Can you just wait a second while…

MR COATES:
Yes, sorry.

GLAZEBROOK J:
1838?

MR COATES:
1838, really at 1839, if I can start there. And just if I draw your attention in that forward in the middle paragraph, I think this is important, "The health strategy provides the framework within which District Health Boards and other

organisations across the health sector will operate. It highlights the priorities the Government considers to be the most important."

Then the next paragraph I think is relevant, particularly, you know, to some of the consultation arguments that have been raised. It has been developed with wide sector and public input. 1500 people attended, 450 submissions, and so forth. "The majority of submissions were positive in their support for the vision of the health strategy," and then over the next page, which is jumping ahead a bit in the actual document but it – you'll see that, "Priority population health objectives," and at the top of the list the number one priority population health objective is reducing smoking. So that's the Government setting out very clearly in its health strategy that reducing smoking is at the top of the list.

And then if I just take you over the page to page, well, it's 14 of the strategy, 1841, you'll see at the second paragraph down, or the first major paragraph down, the last sentence there, this is in my submission highly relevant to the public law responsibilities of the DHB, the importance of these priorities will be recognised in the Minister's expectations of the Ministry, funding agreements with DHBs and DHBs' funding agreements with providers.

GLAZEBROOK J:
I'm sorry, where were you?

MR COATES:
It's at page –

GLAZEBROOK J:
I see, no, I've got you now.

MR COATES:
As I say, these are important public law responsibilities that then get placed on the DHB, and then obviously there's the detail there about reducing smoking. So that, in my submission, really is the start of the story of the

development of the policy, the DHB getting a clear direction from the Government that reducing smoking is at the top of the list.

And then we see and, look, I don't need to take the Court through the detail of it but over the following many years, ultimately nine, almost 10 years, the development of the policy and, look, you know, the story's told in affidavits of five deponents all coming from their slightly different perspective, I think that if I just may make the points that the initial stage of the process was on the main hospital, if I can call it that, and there was a clear recognition that mental health patients had their own complex issues and needs that needed to be worked through, and so the DHB spent a very considerable amount of time doing that. My friend, with respect, isn't right to say that consultation and so forth was just focused on the Mason Clinic. It wasn't and, in my submission, that's clear. When you work through the documents you will see that. There is very extensive sort of engagement with consumer groups, the Mental Health Commission was closely involved, and a whole lot of other groups. And look, you know, I don't, I won't dwell on any of the specific issues but my friend talked about the safety issues relating to smoking off site. Those were clearly taken into account by the DHB and if I don't need to take you to it but if you're interested in some of the issues around safety I'd draw Your Honours' attention to Dr Patton's evidence at page 429, in particular at paragraph 47, and he talks about the complex issues relating to mental health and the balance between, you know, treating people with mental illness in the least restrictive way possible, always if possible trying to treat people in the community. If they can't be treated in the community, in the open ward. If they – it's only the most significantly unwell patients who will be transferred into the ICU.

So as I've indicated, in 2005 the DHB went smoke-free with the express exception relating to mental health, and then there was this very significant pilot project in 2007, 2008, in the Mason Clinic and I do comment Your Honours to the evidence on that which is largely in the evidence of Claire Thompson. She talks about she left that programme and talks in a great amount of detail about what happened there.

So look, you know, I've glossed over, you know, a detailed chronology but in my submission when Your Honours look at that you will see what Justice Asher saw, what the Court of Appeal saw, which was a very careful process over many years taking into account a great number of factors and leading to the ultimate policy in November 2009.

I'm now just briefly at paragraph 11 of my written submission and we've talked a lot already about the offers of nicotine replacement therapy and so forth. I would just like to draw Your Honours' attention to one document and, again, there are a number in the evidence that relate to the steps taken to mitigate the harm caused by smoking but in my submission the smoking guidelines, cessation guidelines, for mental health are particularly helpful and those guidelines are in volume 4, page 1085. Now I don't really need to take you through the detail of them but these are the specific smoking cessation guidelines for the Mental Health Service. You'll see that these are dated January 2011. Prior to that, and they're in the bundles, there were nicotine-dependent inpatient guidelines for the entire hospital, but these ones are tailored to the particular unique circumstances of the Mental Health Service. And look, as I say, I'll leave you to look at those in due course but in my submission the very clear demonstration there is the extent to which the DHB went to make sure that those people who were not going to be allowed to smoke were being adequately supported. This is not a situation where a DHB has simply said, "Can't smoke and suffer the consequences." They've gone to very great extent to make sure that supports are in place to help those people. The only other –

GLAZEBROOK J:
And you were going to take us to the evidence on the effectiveness of those measures, as I understand.

MR COATES:
Yes, and – no, I'd be very happy to do that. I think the starting point, Ma'am, and there's a lot in the evidence on it, but is Dr McRobbie's affidavit and that's

at – and in particular at page 407. That's volume 2. Volume 2, page 407, and if I just start at paragraph 43 at the top you see NRT is the first line of strategy to managing withdrawal symptoms is approving an effective treatment. He then goes on to talk about how NRT works. He talks about the Cochrane report, I'll come back to that in a moment. 45, NRT has been shown to reduce tobacco withdrawal symptoms. Most studies show that it relieves craving, depression, reduces anxiety and so forth. So I think Dr McRobbie, the medical practitioner who specialises in nicotine addiction, in his, I think his evidence is the first place to look. Associate Professor Lawn, whose expertise is in the interface with smoking and mental health, she also addresses it, but I commend most, Dr McRobbie to you.

GLAZEBROOK J:
I sorry, I didn't catch the name.

MR COATES:
Dr McRobbie.

GLAZEBROOK J:
No, no, the other –

MR COATES:
Associate Professor Lawn, Sharon Lawn.

GLAZEBROOK J:
Oh, professor, yes.

MR COATES:
I'm going to resist the temptation, I do want to take you very briefly to the conclusions of the Cochrane Report, other than that I'm going to resist the temptation unless you'd like me to go through the various academic articles. I think it's fair to say there are a number of them and the Court, in my submission, will not be greatly assisted right now by going through and trying to interpret different conclusions that are reached. But I would like to take you

to the conclusion of the Cochrane Report because my friend spent a lot of time on it, and that's at volume 3, page 707, and you'll see there, half way down that page, "Author's conclusions". "All of the commercially available forms of NRT can help people who make a quit attempt to increase their chances of successfully stopping smoking. NRT's increase the rate of quitting by 50 to 70% regardless of setting. The effectiveness of NRT appears to be largely independent of the intensity of additional support," and so forth, and then under the "Plain Language Summary," just below that, four or five lines down, "We found evidence that all forms of NRT made it more likely that a person's attempt to quit smoking would succeed. The chances of stopping smoking were increased by 50 to 70%." So we can get caught up in a lot of detail in some of these learned articles, but that's the plain language conclusion of the Cochrane Report.

WILLIAM YOUNG J:

But it's, in terms of someone who is in ICU, stopping them smoking for two weeks and giving NRT is unlikely to have much effect on their long-term smoking habits. So if that's the justification of the policy it may not be a very strong one, but I imagine there are other policies, that is the impact on other people, the normative effects of the policy and so on.

MR COATES:

Yes, I don't think we've ever said that the main purpose of the policy is to stop people smoking. Obviously we say our job is to promote health and that when you're here you can't smoke, and that's consistent with our objectives. We will make sure that you get what you need to alleviate your nicotine withdrawal, and we'll offer cessation support to maximise the chances that you don't smoke going out there, but I don't think we've ever said the number one objective is to stop people from smoking full stop.

WILLIAM YOUNG J:

But it's probably not even the number – I mean it is a serious objective?

MR COATES:

No I don't think it is. I don't think it is. The objectives are to promote a healthy lifestyle consistent with our purpose, the minimisation of second-hand smoke, and those are the two key ones. Obviously, you know, the services, the cessation services are being offered and if the individuals want to take them up then they're encouraged to do so. There is actually some evidence –

O'REGAN J:

Isn't the point more that the therapy works to reduce the suffering of the people who are being deprived of smoking?

MR COATES:

Indeed.

O'REGAN J:

I mean whether they actually ultimately give up or not is secondary, isn't it, in this context?

MR COATES:

Well I think, I mean we're doing a couple of things. We're certainly giving nicotine replacement therapy to alleviate the symptoms, but we're also offering smoking cessation support and services. So there is a, it isn't just saying here's the NRT, get on with it. We're providing them with systems and means by which they can quit smoking.

ELLEN FRANCE J:

It seemed to me that the evidence of Associate Profession Lawn that you've referred to is quite useful on that topic of the various purposes.

MR COATES:

Yes, indeed, yes. Now there's just one other document I'd like to take you to before really probably turning and just briefly looking at a couple of the legal issues, and it really for me sums up the evidence of Associate Professor Lawn and Dr McRobbie and so forth, and it's a report that has been promulgated by

the UK Royal College of Physicians in consultation with the Royal College of Psychiatrists in the UK. It's at page 1342, 1342, which is volume 4. Volume 4. And I do comment this to you as a neat summary. 1342, although I'd actually really like to take you to 1349 in summary but – now this is a, I think, a 2013 report, joint report of those two august colleges in the UK, and look, just at the bottom of 1349, before I take you through some of the overall conclusions, just above that, and I could take you to all these points really but I won't, the ethical and legal aspects, two from the bottom there, "Smoke-free policies in mental health institutions, as in other public places, are justified on the grounds of health and wellbeing of non-smoking patients and staff. The moral imperative of health care institutions to promote the mental and physical health of their patients, and protect and support the health of their staff, justifies a shift in culture away from one that supports smoking." They then talk in the conclusions about how common it is, the smoking in mental health, and we've talked about that.

Then over the page, seven or eight points down, "There is a moral duty to address this problem in the future, and to prioritise the rights of people with mental disorders to the same protection and health interventions as the general population. Smoke-free policy is crucial to promoting cessation in mental health settings. All health care settings used by people with mental health disorders should therefore be completely smoke free." And the second to last one, "There is no justification for health care staff to facilitate smoking."

So my submission, when you work through that report which I comment to you, you'll see that it's very consistent with conclusions reached by the experts who've given evidence, whose affidavit evidence is before the Court, and the sentiments that are expressed in my submission have been upheld by the Courts in the common law world as I mentioned earlier, Australia, England, Scotland and so forth.

Can I just make on final point on this part of the narrative, and it's a point relating to Mr B himself, and I'm at paragraph 13 and 14 of my written submission, and I'd really just like to draw the Court's attention to the passage

in the evidence which sets out how long and the detail of Mr B's time that he actually spent in the intensive care unit, and the reference is at page 419, volume 2. 419, volume 2. Volume 2, page 419, and you will see there at paragraph 6, this is Dr Patton's affidavit, and the clinical notes are attached as well but I won't take you to those, but he summarises the care and you'll see from that analysis, as we've talked about, that actually Mr B spent pretty limited periods in the intensive care unit. I think interestingly you'll see on the 29th of June 2012 he's admitted to the North Shore Hospital, hypoglycaemic episode for his diabetes, and I just make the point he wasn't allowed to smoke when he was in the general hospital being treated at that time as well.

But in the main, for the vast majority of the time he was being treated by the service, he was in the open ward and he was actually concerned, and he said, his own evidence is that he was concerned about his inability to smoke, even in the open ward, because in the open ward the doors are locked between 9 pm at night and 9 am in the morning, so even on the open side you can't smoke during that period of time. And he was, he made a note of this in his evidence and I'd just like to briefly draw Your Honours' attention to that. It's the same bundle, volume 2, page 283, paragraph 24, this is Mr B's evidence, page 283, paragraph 24. Just starting five lines down, four lines down, it says, "One of the major problems for me with the smoke-free policy is that even in the open ward you were not allowed outside for a cigarette between the hours of 9.00 pm and 9.00 am. Most people do not get to sleep before 11.00 pm and I could not get much sleep. As a result I would go without smokes for hours at night time unable to ignore the cravings and at the same time realising that there was a dedicated smoking room." In my submission that's highly relevant to his discrimination argument. He couldn't smoke when he wanted to and said he suffered as a result of it, even when he was on the open side, and of course this comparator group is the group of patients who are on that open side who – in theory at last, can go to the fence to smoke.

The last point I make about Mr B is that he was admitted to the Mental Health Service in June 2012 which was two years and nine months after the policy

was introduced. The policy was introduced in November of 2009. He's admitted two years nine months after that, he was never a patient when he, of the Mental Health Service, when smoking was permitted.

So what I'd like to do now in the last 10 minutes or so that I have, unless Your Honours would indicate there's anything in particular you'd like to hear from me on?

WILLIAM YOUNG J:
No, carry on.

MR COATES:
I'd really like to just explain, and my friend will spend more time on the rights-based argument, so that was the discussion that I had with him that, to the extent that the detail of the rights-based arguments need to go further than my written submission. My friend can take you through those. So if I just spend my last 10 minutes on the administrative law arguments, and starting really at page 9 of my submission, paragraph 25 and 26, and I've just referred there to what we say are the five key components to the framework here. The first one being, as I've said really, the New Zealand Public Health and Disability Act, which Justice Asher described correctly in my submission, is the source of the DHB's functions and powers. I resist the temptation to take you to the specific provisions in the NZPHD Act, but I do urge you to look at them. They are compelling, in my submission, with the objectives including improving, promoting and protecting the health of people in communities. Exhibiting a sense of social responsibility, being a good employer, and functions including reducing the environmental effects on the health of people and communities. And the terms public health and public health services, they are defined terms in section 2 of the legislation, and in my submission there can be no doubt that steps taken by a DHB to reduce smoking-related harm, and to show leadership on such issues, is captured by the phrase "public health services". That's their job. That's what Parliament has told them to do.

So then turning briefly to the second limb which, in my submission, is the DHB's powers as owner and occupier to regulate behaviour and activity. It referred there to the DHBs being statutory entities. They're Crown agents under the Crown Entities Act with power to do anything that a natural person of full age and capacity can do subject to it being for the purpose of performing its functions, and that means that they can set rules for the operation of its facilities provided that it does so consistently with the objectives.

32, the DHB regulates the behaviour and activities by setting a number of rules, exerting property rights and so forth, and we've covered most of these issues. And as I say there at 33, the need for rules and policies to ensure the safe and effective operation of a hospital is particularly acute in those parts of the hospital that house the most seriously unwell mental health patients. Mental health patients' autonomy must be respected, but at the same time clear boundaries are needed as to what is and is not acceptable behaviour. It's not just drinking alcohol. It's not just watching pornography, as my friend said, which might have an impact on behaviour. There are a whole lot of things. You can't choose what you eat and you can't choose the time that necessarily you have your meals. There are a whole lot of restrictions that are inevitably part of being subject to a compulsory treatment order under the Mental Health legislation. And I've just referred there to the *Rampton Hospital* case which my friend's touched on and I do again commend to the Court as setting out these issues clearly.

My third limb there is the public law obligations. I've really referred to that by taking the Court to the health strategy but there is a statutory responsibility in the Crown Entities Act to give effect to Government policy, and in my submission that is what the DHB has been doing, and it's not just the health strategy. I've referred there at paragraph 36 to the "Clearing the Smoke" plan and there are a number of contractual obligations as well.

The fourth limb, paragraph 39 of the written submission, is the Health and Safety in Employment Act 1992 as it was at the time and obviously now

repealed and replaced with the 2015 Health and Safety at Work Act, and in my submission the lower Courts quite correctly found that the potential harm to employees and others in the workplace was one of the justifications of the policy and obviously the Court's well aware it's set out there the extent to which employers have responsibilities in relation to those who come into the workplace, employees and others.

And I just make the point at paragraph 41 that, and it's a different definition than in the Smoke-free Environments Act. The place of work is very broad. It includes inside and outside. Smoke-free Environment Act definition of workplace is much more limited, the internal space, you'll remember. And ultimately exposure to tobacco smoke is a significant hazard under the 1992 Act which places very significant obligations on the DHB in terms of minimising, reducing, eliminating.

So that's probably pretty clear to the Court the health and safety legislation.

The fifth limb is good medical practice and the Court of Appeal spent a lot of time on this analysing what good medical practice means in this context, and I've just referred in the written submission there to some of the standards that do exist that bind those who provide health services.

I've quoted at paragraph 44 from the health and disability sector standards which impose the express obligation, the express standard, that consumers are not put at risk by exposure to environmental tobacco smoke.

So look, I probably don't need to spend any more time on good medical practice other than to support the Court of Appeal's conclusion that the evidence is consistent with good medical practice and the ethical and quality standards required of a public health provider.

So unless you have any questions on that, I'll just spend the last couple of minutes on the Smoke-free Environments Act and section 6.

WILLIAM YOUNG J:

Well, what's the practice in New Zealand by the different Health Boards? How many have complete smoke-free policies?

MR COATES:

Well there's, the evidence that was before the Court at the time certainly was that all the Auckland DHBs had smoke-free policies. I don't know, there are 20 District Health Boards around the country. I don't know whether every single one –

WILLIAM YOUNG J:

Well the evidence suggests at least Canterbury District Health Board did?

MR COATES:

The evidence suggested that Canterbury did and then they oscillated and went back, I mean this is going back to 2011/12. I don't know what the position is now. I mean clearly the District Health Boards are watching this case with keen interest but, you know, my sense is that – certainly I can say that Auckland DHBs definitely do and that that tends to be the trend around the country.

Can I turn and briefly, if Your Honours would like to hear me on it, on section 6 of the Smoke-free Environments Act.

WILLIAM YOUNG J:

I'm not sure, are we troubled by section 6. Perhaps we'll just have a quick discussion. We'll hear you on that for a couple of minutes.

MR COATES:

Just, my learned junior very kindly, in the evidence on District Health Boards, Dr Patton, page 309, para 27, says, "I understand that most District Health Board impose a similar ban on smoking," so that's obviously an affidavit that goes back a few years now, but that's the evidence before the Court.

So, look, in terms of the section 6 argument. We say that the contextual aspects of the argument simply don't, of the legislation simply don't support the interpretation that the appellant seeks to put on it Look, I think if I may I'd focus just briefly on the implications, the policy implications as much as anything. I mean in my submission the language is abundantly clear and the starting point has to be that you read the language as it's written. It's a 2003 piece of legislation, it's read as granting a discretion, and it's just simply not, in my submission, in the category of other cases where "may" was being interpreted as "must", where there's a statutory decision-maker that's considering statutory criteria set out. This is an employer, a general power given to an employer as an exception to the section 5 prohibition on smoking, to say that if you've got these smoking rooms and so forth, or you want to allow people to smoke, here are the, here's the basis on which you can do it. So in my submission fundamentally a different type of statutory power than you see in the other cases where "may" sometimes is interpreted as "must".

But, look, if I just focus, and this is at 56 and following of my submission, the implications of my friend's interpretation on this are vast, and I don't exaggerate by saying that. If the requirement is that all hospitals, it's not just public hospitals, it's not just DHBs, it's all hospitals that are licensed, it's all rest homes, it's all residential care facilities, if they are all required to have smoking rooms allowing smoking, then that's going to be an extraordinary consequence and imposition on the way they choose to run their hospitals and their affairs. I can say, and the evidence is before the Court, at this DHB, you know, they simply don't have the space. They'd have to create the space, they're using the rooms that were previously smoking rooms for other purposes now, and the Taharoto unit on the North Shore has been replaced by a new unit that doesn't have any smoking rooms, so they'd actually have to physically build spaces to do it, and then put in the ventilation systems that section 6 requires to go in and make the other space available for non-smokers and so forth. Look, it may be a DHB might be able to find the funding to do that, but then that is what every rest home around the country and residential disability care facility would have to do. Some of these are

small facilities and in my submission a very significant policy consequence to give the interpretation that my friend seeks to put on section 6.

Look I, just as a final point on that, in my submission the, you know, the history of the legislation just simply doesn't support it. I've talked about the change over the years from a restricted to a – sorry, permissive to a restricted environment, and the Court of Appeal in the *Progressive Meats Ltd v Ministry of Health* [2008] NZCA 162, [2008] NZAR 633 case addressed this as well, recognising the changing focus and what we haven't referred to, we've touched upon section 6A which was relating to prisons, which allow the policy to be set, of course section 6, and this is in the bundle, section 6 of the original Smoke-free Act, actually required hospitals to have a written policy that effectively mirrored section 6A relating to prisons. So prior to the 2003 amendment, in a hospital you did need to have a smoking room to allow those people who were unable to get up and leave to be able to smoke. Now clearly Parliament changed that definitely and decisively with the 2003 amendments where it moved away from that, so for the Court to now be asked to interpret the current section 6 in the way he suggests is to show no regard to that legislative change that's clearly there.

So look, noting the time, I mean I, you'll have got a sense of, and you'll see from the written submission the DHB's position on the rights-based arguments. I'm minded to hand over to my friend, unless you have any particular questions for me?

WILLIAM YOUNG J:
That's fine, thank you Mr Coates. Mr Rishworth.

MR RISHWORTH:
Thank you Sir. What I propose to do is just to make one general –

WILLIAM YOUNG J:
Have you got a microphone?

MR RISHWORTH:
Is that better Sir?

WILLIAM YOUNG J:
Yes.

MR RISHWORTH:
One general introductory comment and then I will just go quickly through the submissions, but I say straight away that, bearing in mind the time, I'm very happy for any question to be asked on any matter that is of concern to the Court at this stage of the afternoon. So I'm definitely not wedded to going through the submissions chronologically. A general point is this. One would expect the law –

WILLIAM YOUNG J:
Just pause there sorry. I think we're primarily interested in section 23(5) so you may want to focus on that.

MR RISHWORTH:
Certainly Sir. I was going to come at 23(5) through the lens of the 28 argument. Would it be acceptable if I was just to talk about the general liberty to do that, which isn't restrained by law because –

WILLIAM YOUNG J:
Well you've referred to that in your submissions –

MR RISHWORTH:
Yes.

WILLIAM YOUNG J:
In a sort of Hohfeldian sort of way.

MR RISHWORTH:
So the connecting point is simply that if the law is a coherent system and a coherent whole, one wouldn't expect that an argument which is made and

dealt with as part of the idea of a general liberty, to be able to be repackaged and come up again as a 23(5) argument, in other words if it's legitimate to pass a law or to have a policy which deals with the general liberty of people to live their lives as they see fit, and to see if they like, it is acceptable to have a law, or a policy as it is in this case, that can justifiably erode that general liberty, and I say justifiably in the law of administrative law, as my friend has said, takes into account the fact that people wish to smoke, and that many are smokers, deals with that through consultation, through medical advice, through their nicotine replacement therapy, it would then be surprising if something which is dealt with in that way as a legal argument can surface again as a violation of the right to be dealt with with dignity when detained, and I go on to say it would be surprising if under section 19 –

WILLIAM YOUNG J:

All right, well, I mean the idea of a right to smoke entrenched by the Bill of Rights Act isn't in itself particularly attractive. I mean, I think the more formidable argument you face is that stopping someone smoking when that person is detained and the consequence of stopping them smoking is distress and physical symptoms then –

GLAZEBROOK J:

Especially when they're already acutely unwell.

WILLIAM YOUNG J:

Yes. It does raise an issue as to humanity and dignity and, I mean, that seems to me to be the strongest part of the appellant's case.

MR RISHWORTH:

Yes, Sir. Now, my written submissions don't deal quite as fully with 23(5) as the submissions to the Court of Appeal did and on that point the Court of Appeal judgment does represent the submissions that were made by the intervener on that occasion.

WILLIAM YOUNG J:

Okay, well, let's just start at the beginning. What's the standard for us? Are we interested in what the Health Board thinks or do we simply make our own judgement as to whether this policy is one that is consistent with section 23(5), that is one respects the – is consistent with humanity and the dignity of the people affected by it?

MR RISHWORTH:

Yes, Sir. My understanding of that would be that, this being an administrative law case, then the bounds of an acceptable decision that the Health Board could make are constrained to find by observing the rights in the Bill of Rights, one of which is section 23(5), and if 23(5) is infringed, or any of the rights are infringed, then I would say that's outside the bounds of that valid decision.

WILLIAM YOUNG J:

So we don't have to worry about margin of appreciation or rational processes and thinking. We just go straight to the point, is this humane and does it respect the dignity of those affected by it?

MR RISHWORTH:

Well, you go straight to the question, Sir, but in answering the question if one starts, say, with one of the rights to which section 5 is more obviously germane, like speech and religion, leaving dignity aside for a second because that's in that category where it's an evaluative sort of term, but taking the other more – the rights to which section 5 is at, then in deciding the question has the Bill of Rights been breached so that you're outside the bounds of a lawful decision, there is obviously the question of reasonableness, then the question –

WILLIAM YOUNG J:

Well, I would have thought that in this case the reasonableness is really all included in the concept of humanity and dignity.

MR RISHWORTH:

Exactly, Sir.

WILLIAM YOUNG J:

So I would have thought there's really only one question, not two. If you say it's inhumane and undignified, to use slightly the wrong word, I don't think you'd then go on to say, well, it's nonetheless fair and reasonable.

MR RISHWORTH:

No – yes.

WILLIAM YOUNG J:

What you'd say is that the practicalities of intensive care in a psychiatric institution are such as to dictate this result and so – and therefore it's not inhumane.

GLAZEBROOK J:

It may be clash of rights though because in fact the curtailing of smoking was mostly because of rights of non-smokers and therefore a clash of two rights.

WILLIAM YOUNG J:

Yes.

GLAZEBROOK J:

And one could say a clash of rights of non-smokers, the right to life, which is one of the total pillars of the Bill of Rights Act.

MR RISHWORTH:

Yes.

GLAZEBROOK J:

So it's a clash of rights against wanting to kill yourself and kill others, if you like, if you wanted to put it in very stark terms, and therefore difficult to say even if it's a right rather than a value that it's not justifiable, if you're looking at that clash.

MR RISHWORTH:

Indeed. So my first response to what's been said by both of Your Honours is that yes, the right to dignity, obviously to assess whether that's been breached one is looking at it just in terms of the definition of the word "dignity". One asks why is what is done being done? Is there a good reason and is it done in a way which preserves that dignity and doesn't infringe it in the sense that it's guaranteed? So you've got the same sort of analysis as you might have under the section 5. You're looking at objective and means.

Now responding particularly to Justice Glazebrook's observation about the motivation being essentially the second-hand smoke one.

GLAZEBROOK J:

Sorry, I wasn't talking specifically in respect to this. I was talking about the more general motivation of the Smoke-free Environment Act. It says so, actually, as its purpose.

MR RISHWORTH:

Yes, certainly, yes.

GLAZEBROOK J:

So I'm not making that up.

MR RISHWORTH:

No, no. But in the hospital environment we've heard from my friends for the hospital that it's a multifaceted policy and the general sending of the signals against smoking, that a hospital shouldn't be having smoking in its premises, is a part of the matrix of purposes. It might be of assistance also to those who are detained because although the figures were, I think, was it between 11 and 19% on one survey and up to 3%, that's not insignificant. In any event, it's enough to say that there is certainly a legitimate objective in what is done. So then the question becomes, given that objective, is what is actually done, are you able to say of it that it treats people humanely and with dignity? The first thing I would say to that, Ma'am and Your Honours, is that it does treat

the detained persons with dignity to see them as persons who can benefit from their time in the ICU, which we've heard might be 11 days or relatively short periods, that such benefit as there is from smoking cessation therapy and counselling is available to them. If that comes at the cost of symptoms such as headaches and the aggravation that goes with nicotine withdrawal, then that has been specifically addressed over a long period of consultation with clinical advice, expert advice and the response is nicotine replacement therapy.

GLAZEBROOK J:

But they – when they're in the open unit they will also have the benefit of counselling, et cetera, and nicotine replacement therapy and, in fact, in that period it's much more likely to be effective than, I think, as Justice Young put, the 10 days that you might have in ICU when you're already acutely unwell. So I'm not sure you can say the purpose of putting them into ICU and having a very short-term withdrawal of actual smoking is going to be terribly efficacious in actually stopping them smoking. It would be the longer term cessation policies that they have more generally.

MR RISHWORTH:

Well, of course, the purpose for them being in ICU in the first place is the they're meeting the statutory tests for a compulsory treatment order which is obviously they're in there because of being a danger to self or others or because their treatment necessitates their compulsory treatment. So obviously they're not in there for smoking therapy. But while there, of course, they must be treated with dignity, because they are detained, 23(5) applies, and you have concurrent findings in the two Courts below assessing the evidence in the affidavits assembled by my friends in front of me that the treatment that is given is, meets the standard of 23(5), that it meets the – it's humane and doesn't fail to treat them with dignity.

So the Court can have comfort in the fact that that assessment has been made by all Judges who've heard this case.

WILLIAM YOUNG J:

But there's obviously sort of quite a lot of controversy about it in terms of the affidavits because Mr Francois was able to come up with a number of clinicians who didn't go much on the policy. So, I mean, it's not an entirely easy sort of an issue for us to determine based in a way on sort of competing affidavits, not all of which really engage with each other because to some extent they're talking about different things. The Health Board is looking at it in a more general, I suppose, sense of not hugely focused on the particular wellbeing on the particular patient but rather the way in which the institutions operate and the interests of everyone concerned whereas the clinicians are saying it's very undignified for patients who are compelled to go out on the street and smoke if that's the policy or are in this case unable to smoke.

MR RISHWORTH:

Yes Sir, and of course I guess more for my friend Mr Coates to speak to the hospital board's evidence which I don't have with me, I think it's lying on the floor, on the fifth floor of the Justice Centre. But the Court can have comfort in the fact that the courts overseas looked at the same question, which is the *Rampton* case and the *McCann* case in Scotland, that similar decisions have been reached on the basis of the same sorts of things, sorts of clinical evidence that's been given. In those two cases, as Your Honour pointed out, both where people are in hospitals for a much longer time under conditions of perhaps having committed crimes so I think in Mr McCann's case for a very, very long time, I think at least eight years.

WILLIAM YOUNG J:

There's no case where this sort of policy has been held to be inhumane?

MR RISHWORTH:

Not of which I'm aware Sir. And all cases of which I'm aware are in the submissions, both of myself and my friends. But of course in the UK cases the argument is put in terms of the right to a private life, which connects to the point that I began with, which was that if put in that way, and the answer is, well, the denial of a liberty to smoke as and when you will, because you are a

detained patient, is not an invasion of the right, or if it is it's a justifiable one. I say that it can't be repackaged as an infringement of the right to dignity, and the very same argument that –

GLAZEBROOK J:
What's it justified on, though, if it's not health of others?

MR RISHWORTH:
A smoking ban generally you mean?

GLAZEBROOK J:
Well because clearly the purpose in the community is second-hand smoke, isn't it, and in workplaces?

MR RISHWORTH:
That's the Smoke-free Environments Act, yes.

GLAZEBROOK J:
So what's it justified with if there isn't that danger to others? Of course I know the Health Boards say that it's impractical because there will always be those difficulties with other people and the using of the outdoor spaces doesn't work et cetera, so I'm leaving that aside for now, but that's one of the Health Board's major justifications is health and safety of other people, and then to a slightly lesser extent health and safety of the patient themselves, obviously if smoking is clinically, if you have chronic bronchitis then smoking is going to make that worse and therefore it has a health detriment specifically relating to that.

MR RISHWORTH:
Yes, no I think it's more than that –

ARNOLD J:
Isn't there a broader objective, though, in the policy documents we were taken to the Government policy is to discourage smoking, generally, because of the

cost it imposes on the community and the Health Board has effectively taken that on board and one of its planning documents that I read referred to this right up front, this overall objective of reducing smoking, and so I suppose there's that broader context in which these decisions are being taken.

MR RISHWORTH:

Absolutely Your Honour and one sees this very clearly in the two cases from the UK. Maybe it would just assist, seeing we haven't opened the bundle of authorities, just to look at the *McCann* case to see where that is discussed.

ARNOLD J:

Is that in your bundle?

MR RISHWORTH:

Yes, it's in the intervener's bundle, it's at tab 14, the case is *McCann*, and it's – the paragraph I'm interested in is paragraph 8 on the third page under the heading "Government policy".

GLAZEBROOK J:

Sorry, where are you?

MR RISHWORTH:

Tab 14.

GLAZEBROOK J:

No, I've got the tab. I just don't know where you're starting from.

MR RISHWORTH:

Paragraph 8.

GLAZEBROOK J:

Paragraph 8, thank you.

MR RISHWORTH:

And so there you see that in Scotland the relevant document is *Smoke-free Scotland: Guidance on smoking policies for the NHS*, and very clear in that case that Government policy was exactly, as His Honour, Justice Arnold, says, was to move to a smoke-free nation consistent with the liberty that people have, of course, in their own homes to live their lives as they see fit, but the positive encouragement of the equivalent to the Hospital Board, the NHS, to adopt a smoke-free policy for its premises, including its grounds. So there was no requirement, this is further down paragraph 8, to provide outdoor smoking. Sorry, just reading above that, this is the executive summary, "Those working in the NHS 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." So there it's very clear as a matter of Scottish policy and the position in New Zealand appears to be the same although my friend would be more familiar with that for the Hospital Board but it is in the affidavit evidence.

WILLIAM YOUNG J:

Is there nothing in the UK human rights set-up that corresponds to section 23(5), because *McCann* and the other case, *N* or – what do you – you mentioned – someone mentioned the name before.

MR RISHWORTH:

It's the, well, I think it's called the *Rampton Hospital* case. It's *re (E)* and *re (N)* but it's all about Rampton Hospital. Yes, same arguments there.

WILLIAM YOUNG J:

Okay, so – but they're focusing on article 8?

MR RISHWORTH:

They are.

GLAZEBROOK J:

The UK does tend to try and cram quite a lot into article 8, I have to say.

MR RISHWORTH:

Yes, because it's a – well, I suppose it's the EU or the European Convention system that does. It's the equivalent to the right to liberty in the American constitution, Canadian *Charter*. And, of course, every country pushes these sorts of cases through its own prism and here, not having article 8, the relevant prism is 23(5), but my point is simply that the argument is not improved by being pushed into different packages. It's the same argument. Certainly not section 9 or 19. 23(5) might come closest in this country to what article 8 does but it's still the same argument, and in my submission it's not clear that New Zealand is any different from the position that we see in the Scottish case, same issues. It's one of these issues that has its day around the world in the highest courts of many countries. In this context it's smoking and mental institutions but, of course, there are other controversies like abortion and so on and so forth, but they're all put in the language of a country's own system but it's the same issue.

ELLEN FRANCE J:

Am I right in the Victorian context, the Victorian case, theirs is a dignity right, one of the rights?

MR RISHWORTH:

Yes, that's the case…

ELLEN FRANCE J:

That's at your tab 12.

WILLIAM YOUNG J:

De Bruyn.

MR RISHWORTH:

De Bruyn, yes, tab 12. Yes, the more modern Human Rights Acts tend to use the word "dignity" rather than "private life" or "liberty". So in this case I think there were, just looking at the index, yes, has the dignity right been engaged?

ELLEN FRANCE J:

And as I understand it the conclusion there is that it doesn't infringe.

MR RISHWORTH:

It doesn't infringe, and in that case also, because of the wording of the Victorian Charter, there's a positive obligation to have regard to rights in the Bill of Rights as well as implicitly to observe in the decision and make, and nor was the right to have regard to the rights infringed. Paragraph 127 is relevant, on page 53 of the judgment, this is the conclusion, that's beginning half way through, "Not every act which causes inconvenience, distress or even pain is inhumane and not every act which limits the rights and freedoms of individuals can be said to be made without respect for the person's dignity. Further, what may not be inhumane or an affront to a dignity of a person, who is free to return to his home, may be one or both of those things to an involuntary patient who suffers from mental illness and resides in an institution." And then it sets out the relevant circumstances on the one hand, on the other, and so if that point is allowing for a possibility that being detained is, in fact, a relevant consideration here, but the conclusion, this is now over at page 55 at (d), "I consider that the implementation of the smoke-free policy has been preceded by a number of years of careful consideration of the advantages and consequences, consultation with affected groups and with appropriate strategies to ameliorate negative effects."

ELLEN FRANCE J:

In terms of the argument today it seemed to me that paragraph 129, paragraph (c), was perhaps more relevant.

WILLIAM YOUNG J:

Sorry, what number?

ELLEN FRANCE J:

129(c), that's on page 55.

MR RISHWORTH:

Yes.

ELLEN FRANCE J:

Just in terms of the question about evidence as to the NRT and so on.

MR RISHWORTH:

Yes, "Introduced in this manner," that's the policy, "it is difficult to suggest that the smoke-free policy constitutes treatment of the plaintiff without humanity and without respect for his inherent dignity."

GLAZEBROOK J:

Although the reference is to this case.

ELLEN FRANCE J:

Yes, yes.

MR RISHWORTH:

Although page 55, paragraph, footnote 55, I'm sorry, just above, because it's reference also to the Scottish case, so I suppose the point being made is there's a general international coherence about what's being decided and that was to our, to the High Court case in this case at the High Court level, but to the Scottish case before the Inner House. It might be of interest to the Court that the Scottish case is on appeal to the UK Supreme Court.

WILLIAM YOUNG J:

It is on appeal now?

MR RISHWORTH:

The appeal has been heard but there's been no decision. So it was, I think, just two or three weeks ago.

GLAZEBROOK J:

That's the –

WILLIAM YOUNG J:

McCann.

GLAZEBROOK J:

McCann.

WILLIAM YOUNG J:

Okay, well that's probably all you want to say about section 23(5) is it?

MR RISHWORTH:

It is Sir.

WILLIAM YOUNG J:

I don't want to stem your flair necessarily so what else would you like to say?

MR RISHWORTH:

Well I was going to say something about section 19 but I'm happy not to and rest on my submissions.

WILLIAM YOUNG J:

This is discrimination?

MR RISHWORTH:

It is, yes.

WILLIAM YOUNG J:

So what do you say about section 19, in a nutshell?

MR RISHWORTH:

In a nutshell, it's – well, it's this, Sir, that if one looks at the section 19 cases we've had, they've been essentially benefits cases, like the *Ministry of Health v Atkinson* [2012] NZCA 184, [2012] 3 NZLR 456 case about disability services or the CPAG case about the Working For Family tax credit [*Child Poverty Action Group v Attorney-General* [2013] NZCA 402, [2013] 3 NZLR 729]. This case is in a slightly different category because it's what I would say

is a liberty right sort of case. That is, instead of having a challenge policy which builds in some ground of discrimination like you're a relative so you can't be paid to look after your children or you're on the unemployment benefit so you can't get a tax credit, this case is different because it's a general neutral in discrimination terms policy. Applies to everybody. Nobody can smoke in the District Health Board premises. The real claim, I say, is actually the private life liberty right claim.

GLAZEBROOK J:
Is what, sorry? Real claim is?

MR RISHWORTH:
The real claim is the private life claim.

WILLIAM YOUNG J:
But this is saying section 90 doesn't matter, look at the rest of it, does it, or not?

MR RISHWORTH:
I'm saying that if the right to – if the liberty claim doesn't succeed then –

WILLIAM YOUNG J:
Sorry, but what's the structure? What structure should we adopt for looking at the section 19 claim? I mean, the case for the appellant's simple enough. He's not allowed to smoke because he's got a – he has a psychiatric illness as a result of which he's held in a secure unit, so he's being treated differently from other people. Now what's your answer to that?

MR RISHWORTH:
Well, it's at page 15, paragraph 59, of my submission, Your Honour.

GLAZEBROOK J:
Sorry, would you – I didn't catch the paragraph number.

WILLIAM YOUNG J:
Para 59.

GLAZEBROOK J:
59?

MR RISHWORTH:
Page – it begins at paragraph 59. It's on page 15 and it really would be down, I think, at, let me think, paragraph 64 where I say that there are several ways in which the claim might be framed, depending upon the proffered comparator group. The Attorney-General supports the approach taken in the Courts below, and then in paragraph 65 suggests that a useful starting point is to consider the context, that is to say a patient who's in the unit, the ICU, is in there because they're a serious danger to themselves or others or lack the capacity of take care of that person himself. Once they're in the unit, the constraint on their smoking is simply a consequence of being in that place rather than in another place.

It's actually the same argument as is made under the right to life way of looking at it or the dignity way of looking at it. I'm saying it's not improved by being cast as discrimination. I'm saying that if it doesn't rise to the level of being a breach of any of the – the suggested common law right to a private life, then it's no more salient for discrimination purposes that you cannot smoke when you're in the ICU than it is that you can't dine when you would like or with the guests that you would like. It's simply one choice amongst others that is taken away.

If you focus instead on the dignity or humanity argument which is that, well, if it's not choice then it's the pain you feel because of the nicotine withdrawal. Then I say to that the answer is then the same as it is for section 23(5), or the right to private life if that's the way you're packaging it. It's the same answer as is given in the other cases and in this one in the Courts below. There is no breach of dignity because of the careful way in which that has been addressed by the authorities. Given that, it doesn't suddenly become salient

for discrimination purposes. What would make this a discrimination case is if there was a room to smoke in and then it was said, "Oh, but you can't go in there if you're of a certain acuity of mental illness," or if you have a certain gender. But it's not a case like that where benefits are held on the direct discriminatory grounds. It's a liberty case.

WILLIAM YOUNG J:
It's a what case?

MR RISHWORTH:
It's a liberty case.

WILLIAM YOUNG J:
Liberty case.

MR RISHWORTH:
It's a claimed liberty to smoke as part of a claimed right to a private life. In my submissions I say that in New Zealand there is no counterpart to article 8, only a common law residual liberty, which is no barrier against a law being passed that takes it away. When it's a policy that's taking it away, as it is here, of course that liberty to smoke is taken into account, as it was in this case, because why would there have been all this consultation and concern but for the fact that it was recognised that well, when we introduce a smoke-free policy, we can't do that without reckoning with the fact that people wish to smoke, and that it might be of some harm and discomfort to those who do. My point is that all of these things were thought of and addressed on their own terms. They cannot be the subject of a legitimate complaint, whether that be packaged as private life, dignity or discrimination. It's the same argument put in different ways, and the evidence for that being so is the way it gets resolved in the same sorts of ways around the world.

So that's my argument on discrimination. That one has to ask, what is actually being suffered by the complaint group? The claimant group are my friend's clients, Mr B, and the group he represents, but when they're in the unit

it's not that they have a psychiatric illness that is the salient point about them, it's that they want to smoke.

WILLIAM YOUNG J:

Well the policy affects everyone in the unit whether they're under compulsory treatment orders or not, so it affects the staff and visitors as well, which the Judge in the Australian case, the Victorian case saw it as being of some moment.

MR RISHWORTH:

Yes, it treats everybody the same, and that's certainly exactly so, but the point that I was making was simply that when somebody is in that unit as a person who suffers under that policy, because they like to smoke but can't because of the policy, one asks, well, in what capacity are they suffering. I'm saying, well, as a smoker.

WILLIAM YOUNG J:

Or as a person who is physically present there.

MR RISHWORTH:

Or as a person that's physically present there, which is not the same as, not everybody with a psychiatric illness is there. It's those who are judged to be amenable to a compulsory treatment order.

WILLIAM YOUNG J:

But couldn't people subject to a community treatment order be a class of people for the purposes of section 19? I mean the list of prohibited grounds of discrimination refers to psychiatric illness, but couldn't it include people with a particular type of psychiatric illness ie a type that warrants a compulsory treatment order?

MR RISHWORTH:

I'm not sure that it could, Your Honour, not without doing some violence to the categories in the Human Rights Act 1993. Now I certainly go along with my

friend Mr Francois to say that you can have intra-ground discrimination, and that those that have acute illness, as compared to those not so acute, I can understand there might be situations where that distinction is drawn. I'm just saying that to get into the ICU it's whether it manifests in a certain way that causes violence or harm to yourself or others, and it's that propensity for harm that is then the salient point, not the psychiatric illness itself. Rather like the *Purvis v New South Wales* [2003] HCA 62, (2003) 217 CLR 92 case in the High Court of Australia.

WILLIAM YOUNG J:
But you can't be, by and large you can't be held compulsorily because you're a dangerous person, unless that danger is caused by psychiatric illness.

MR RISHWORTH:
That's true but it's a combination of the two. It's in the category of psychiatric illness, those who are a danger to self or others, and it's that category, a danger to self or others, that's then in that unit, and all I'm saying is that it's another way of looking at it that isn't discrimination on a prohibited ground but on what has been done or may be done by a person.

WILLIAM YOUNG J:
I mean I find the whole point quite elusive because obviously those who are subject to compulsory treatment orders are being dealt with differently because of that status, that is they're being held compulsorily.

MR RISHWORTH:
That – yes.

WILLIAM YOUNG J:
So – and all the incidents of that – there are a whole lot of incidents follow that. For instance, not being able to walk the streets. As I think Mr Coates said, not being able to eat and drink when you want to or what you like, and currently not being able to smoke.

MR RISHWORTH:

Indeed, and that's why I say that the best way to look at this case is through the lens of it being different from the other discrimination cases because what's at stake really is the demand to say, "Here's something I'd like to do which I ought to be able to do." If you win on that argument that you ought to be able to smoke so as to overcome the ban, that's enough for the win. If you don't win on that argument, as I say the appellant here doesn't and no appellants overseas have, then it can't be repackaged as discrimination because then it not being a right that is salient in any legal sense it's like –

WILLIAM YOUNG J:

But you can be discriminated against in respect of aspects of life that aren't really rights. I mean, people who want to buy a cake with a same-sex couple on it to celebrate a wedding, I don't know that buying a cake is a right.

MR RISHWORTH:

No, but –

WILLIAM YOUNG J:

But that's discrimination.

MR RISHWORTH:

That's a direct discrimination.

WILLIAM YOUNG J:

Sorry?

MR RISHWORTH:

That would be a direct discrimination.

WILLIAM YOUNG J:

Yes.

MR RISHWORTH:

"I'm not selling you this cake because of your marital state."

WILLIAM YOUNG J:

"I'm prepared to make wedding cakes to everyone's prescription but I'm not prepared to make one that has a – celebrates a same-sex wedding." Now the cases say in other jurisdictions that that's discrimination.

MR RISHWORTH:

Yes, and I say that would be like *Atkinson* and *CPAG* where you've built your discrimination into your service.

WILLIAM YOUNG J:

But, sorry, but I'm just saying that – but you can't really just say that the ability to buy a cake is a right.

MR RISHWORTH:

No, but if you are going to enter into the market of providing cakes –

WILLIAM YOUNG J:

Yes, but if you are going to enter and hold yourself out as prepared to supply cakes to all and sundry, well, then you've got to do that.

MR RISHWORTH:

Yes, that's the crucial difference.

GLAZEBROOK J:

Well, I suppose what you're really saying here is what it comes down to is the lack of choice because of detention, not because – and the detention has come about through the mental illness but the lack of choice is through the detention and if Mr B doesn't win on detention then he's not going to – then he shouldn't win on discrimination. Is that – it's the same argument effectively.

MR RISHWORTH:

Yes, yes, I suppose that is it. If the law of the land provides for the possibility of detention for various criteria, in this case Mr B, those criteria are satisfied. He's in detention.

GLAZEBROOK J:

Because he can't buy a cake either.

MR RISHWORTH:

Yes, yes.

GLAZEBROOK J:

In fact, one –

MR RISHWORTH:

Exactly.

GLAZEBROOK J:

Or at least not directly.

MR RISHWORTH:

Yes, because there's no right to buy a cake and there's no right to smoke. There is the right to have your private life not interfered with although in New Zealand more of a political moral right than the hard-edged one that we see in the UK. But even if there was such a right, we'd be entering into the realm of is it reasonably limited as under article 8(2) which all the cases would say yes, it would be if we were even entering into that. So –

WILLIAM YOUNG J:

Well, if it's the treatment that – if he's being treated humanely and with dignity and there are legitimate policy reasons for the smoking ban which justify those conclusion then that probably would justify the discrimination.

MR RISHWORTH:

Absolutely.

WILLIAM YOUNG J:

Okay. Well, I've recently found this rather an elusive aspect of the case.

GLAZEBROOK J:

Yes.

MR RISHWORTH:

Well, it is the thing about you wake up every morning when you're thinking about this case with a new angle on the comparator groups, but that's why I suggest it's helpful to come at it this way and say, "Why is this a difficult case?" Each one is difficult in its own way but I suggest the answer to this one is by approaching it through the lens of saying, "What's really being claimed here?" and I'm suggesting it's the liberty to smoke, and once that's dealt with I'd say everything falls away, 23(5), certainly section 9, and section 19.

WILLIAM YOUNG J:

Okay. Have you – that's at –

MR RISHWORTH:

That will be all.

WILLIAM YOUNG J:

You're done?

MR RISHWORTH:

I'm done.

WILLIAM YOUNG J:

Okay, thank you, Mr Rishworth. Mr Francois?

MR FRANCOIS:

I was wondering, Your Honour, if we could just have a brief five-minute adjournment and I'll be finished by 4 o'clock.

WILLIAM YOUNG J:

Sure, yes. No, that's fine. No, we're doing well for time, I think. Right, we'll retire.

COURT ADJOURNS: 3.29 PM
COURT RESUMES: 3.37 PM

WILLIAM YOUNG J:
Right, Mr Francois.

MR FRANCOIS:
May it please the Court, I did indicate I'd be finished by four. It may be –

WILLIAM YOUNG J:
No, that's fine, that's fine.

MR FRANCOIS:
It may be before then. I may be only 10 minutes, Your Honour.

WILLIAM YOUNG J:
No, you've done very well.

MR FRANCOIS:
I just wanted to – I've got about five or six points and all I'm doing is just covering, I'm not repeating, a short closing I believe is a better one than a long repeated one. So I wanted to speak firstly about the fact that this is not just Mr B's case. My friend has focused a lot on Mr B's confinement –

WILLIAM YOUNG J:
Well, I don't think you have to, I don't think we would see it as Mr B's case. What we might see it as is a policy that on the whole applies to people who are in intensive care for comparatively short periods of time compared to say people in prisons.

MR FRANCOIS:
Excellent.

WILLIAM YOUNG J:
Is that really the point you want to make?

MR FRANCOIS:

That is part of the point but I will just say a little bit more, and that is that it –

WILLIAM YOUNG J:

I'm sorry, I should add, I think, unless they're in the Mason Clinic when they might be there for years.

MR FRANCOIS:

Yes, and I'm not – and I just wanted to make that clear as well is that this is not a focus on the Mason Clinic, this case, and I'll come to that, but this is – it's not a focus. I did not have access to that clinic. The appellant had no access. There's not one client of mine who is in the Mason Clinic that is part of this case, never has been. We were not in a position to respond to their evidence but I'll just deal with that a little bit later. It's not, I want to get back to the point about people in the ICU who are there on short stays. Generally that is correct. But remember patient G in a representative capacity by Nurse Steele, 12 months. That's a very long time.

WILLIAM YOUNG J:

Was that 12 months in one go or over a period of time?

MR FRANCOIS:

No, it was 12 months in one go. Because he just became, he was a difficult, a unique, shall we say, patient in that he had a Huntington's disorder condition.

WILLIAM YOUNG J:

Yes, I know. And schizophrenia?

MR FRANCOIS:

I think, part of it. And you can find a discussion about his case through Nurse Steele's affidavit at volume 2, page 371. I don't need to take you there but all I say is if you want to look for somebody longer than a period of two to three weeks, or a period of a few days, he is an exception and not just, he's an exception in this case, but of course there are other people like him, and in

fact there was a recent case which I think Dr Tony Ellis was involved in. I don't think it was the Waitemata District Health Board but that was a patient who was in ICU for even longer than 12 months. The name eludes me now but it was recently in the newspapers. So just to make that point, in a certain way it is a little bit like a class action.

The next point is a legal right. My friends have said there really isn't a legal right to smoke. Technically that's correct in terms of the Bill of Rights. There is no right to smoke of course. Of course this case is about, we package it, if you like, as a right to humanity, dignity so on, but there is a legal right if we interpret the words in section 6 as "may" means "must", because that does create a legal right, and the case law says that. *Julius* in the House of Lords said that quite clearly.

GLAZEBROOK J:
What about the point about small rest homes et cetera in terms of Parliamentary purpose that was made against you?

MR FRANCOIS:
Yes, the thing about this is that I know my friends are saying it is going to create this, this could create, if Your Honours were to decide this matter in my client's favour is that it's going to create a lot of problems with other rest care institutions or whatever. This is a very narrow focus, with this case, and I think it's very important. It wasn't in the High Court. We changed that. When we appealed in the Court of Appeal the points on appeal were far more focused, narrow, and it became only people in the ICU in psychiatric units.

ARNOLD J:
Yes, but the interpretation of section 6 is not limited in that way –

MR FRANCOIS:
Oh, yes, yes.

ARNOLD J:

If you interpret section 6 as imposing a mandatory requirement it, in fact, would apply across a range –

MR FRANCOIS:

That is correct. Your Honour is, sorry, I misinterpreted. Your Honour is correct there. If it's a legal right created by the interpretation of section 6 then, yes. I don't think we can get, although there maybe ways to limit that because remember we're saying too that it's, we don't necessarily say you have to have a room. Remember we say you can have a designated outdoor area like the cage which has room-like qualities that fit into the criteria. Now I don't know if you could find that in, say, some of the institutions that Your Honour is suggesting.

ARNOLD J:

By the way, what about the complaint that your friend drew our attention to, the 9.00 pm to 9.00 am period on the open ward when they're locked in. Does your analysis apply to that?

MR FRANCOIS:

The 9.00 am to 9.00 pm –

WILLIAM YOUNG J:

Other way around I think.

MR FRANCOIS:

Sorry, 9.00 pm to 9.00 am, yes, even when you cannot smoke, even in the open ward, we would say you have a, if you have a designated area to smoke, then you should be allowed to smoke in it. Now that may be logistically, there may be logistic reasons why you can't do that now but I do know that before when there were designated rooms, without giving evidence from the Bar, but they did have, you were allowed to smoke at like 11.00 pm. The reason why you can't now is because you can't walk outside. But if you had, for example, a cage or, you know, a secure area then logistically I don't

see the same sort of problem. That's exactly the same as what it used to be. So to me it's not a big issue.

I just want to say too before I leave the point about the legal right that it's up to the – if there is uncertainty about this, section 6, it's up to Parliament to do something about it. Democratic endorsement of some sort of change of the law is required, which entails debate. We haven't had that. In all those other cases, *McCann* and *Rampton*, there were changes to the law. There were changes that had these exceptions. They were brought into regulations and then further on down-delegated and then exempt. In the case of *Rampton* it was only a very temporary right to smoke, if you like. Here, it's a primary statute, and I know my friend says, "Oh, but, you know, it's just an employer," but if you look at those cases going back to *Julius*, *Julius* was a – it was about a church, about a church, one of the, who was he, the bishop. Before that there were sheriffs who were given these discretions. To me, it's not an obstacle that it's an employer. The obstacle for the respondent is that it's a primary statute unlike the other cases where it's been delegated and there's regulations that don't have the protection that a primary statute has.

GLAZEBROOK J:
But I'm not quite sure I understand that point.

MR FRANCOIS:
Well, with the other cases it's quite easy to change the regulations. If this is – sorry, Your Honour, this is probably, I should have said, I'm saying if "may" means "must".

GLAZEBROOK J:
All right.

MR FRANCOIS:
Sorry. That requires a law change. It requires something solid. There's protections there. The regulations in the *McCann* and so on, you can change those quite easily without going through Parliament. Here, I say, or

the appellant says, if it is a “must” then it creates a legal right and it can only be taken away by Parliament.

GLAZEBROOK J:
What do you say about the point that was made about the 2003 amendments and then not necessarily being able to go back therefore to what was said at the introduction?

MR FRANCOIS:
Yes, I looked at – I did note that down, Your Honour. It’s – I don’t think it changes much. Then –

GLAZEBROOK J:
Well, it may mean that the reliance on the introduction speech by Helen Clark is not able to be relied on to the same extent and it may be that the changes in relation to prisoners in 2003, and as I understood it also in relation to section 6, might have some effect as well, and I must say nobody has quite put it in that way before and I’m not sure that your friend quite put it in that way but…

MR FRANCOIS:
I just look at the point from the purpose of the legislation in 1990 and Helen Clark’s statement is very strong. I don’t know if the 2003 changes, and I don’t quite know exactly what my friend’s words or the words that he relied upon to –

GLAZEBROOK J:
I think he was talking about the requirement for a policy being the same as the prisoner’s requirement before 2003 and therefore the removal of that.

WILLIAM YOUNG J:
Well, the original section 6 required a policy which permitted patients to smoke.

MR FRANCOIS:
Yes.

WILLIAM YOUNG J:
So the Prime Minister of the day was talking about a statute which was materially different from the statute we now have.

MR FRANCOIS:
There was a requirement to have a written policy if you were going to allow smoking in your environment, in your work environment. That did change and so only because a lot of people didn't – the reason behind that was because a lot of the employers didn't actually bother doing these written policies and it was more a case of, from what I recall, one of just simplifying things.

When they removed the requirement for the written policy, they had to make an exception for smoking indoors and that's why they had these designated smoking rooms in the prison. The prison had to have a policy, as I recall, because, well, I can't remember exactly, but I think the point we get back to is that yes, they may be different pieces of legislation but the purpose is still that you allow these exceptions for certain types of people that you don't have a blanket ban to penalise a certain group of people because they are addicted. I think the exception is still there and the purpose of the exception is still the one that the Rt Hon Helen Clark was referring to.

I could take – well, no, I won't take that any further because we're out of time, but I do remember reading something about that before. Anyway, it may come to me before I finish.

I just want to make a couple more points. Now let's get to the point about the policy objective because that's important here. My friend is kind of down-playing it but let's just turn to it. Let's just turn to the policy objective because my friend is saying, well, it's really about promoting healthy lifestyles. I just want you to look at page 976 in the – which is volume;

WILLIAM YOUNG J:
3, I think.

MR FRANCOIS:
At volume 4, I believe.

WILLIAM YOUNG J:
Volume 4.

MR FRANCOIS:
Sorry, yes, it is. Yes, it is volume 4. Volume 4, 976. Now at the top, first paragraph, it simply reads there, "WDHB is required to ensure that employees, patients and members of the public are protected from tobacco smoke in the workplace." Well, that's obvious. Then, "WDHB has a responsibility to encourage and support patients and staff not to smoke." So it is clearly a policy that is to try and stop people from smoking, and in terms of the rationality argument that simply doesn't apply to psychiatric patients in the units.

Now the other policy objective, the promotion of healthy lifestyles, we have to bear in mind that this is somewhat hypocritical. The double standard is somewhat absurd when we consider that the WDHB really doesn't do anything in terms of obesity. If people, patients are obese, they don't suddenly put them on a weight-loss programme. They don't refuse to –

GLAZEBROOK J:
Some might say the hospital food does that for itself.

WILLIAM YOUNG J:
But probably they do have a policy of providing nutritious and appropriate food. They don't probably stop people eating other food as well.

MR FRANCOIS:
No, and they, look, you can eat all. It's kind of –

GLAZEBROOK J:

I think some of them do actually because of the effect on other patients.

MR FRANCOIS:

You can eat – although you can eat, like when they put the food out for the patients, you can come back for more and more. I mean, it's just put out there as a smorgasbord on it.

WILLIAM YOUNG J:

This is slightly off the point though, isn't it? I mean, we can't say, well – I mean, it's most unlikely that we would say that this is an irrational policy because what's the Health Board doing controlling smoking and not eating or controlling smoking and not making people go to the gym for an hour a day?

MR FRANCOIS:

No. No, I'm not asking you to decide that. I'm not asking you to use that in terms of your analysis. All I'm saying is that, you know, that there is a big emphasis on smoking whereas obesity, according to the World Health Organisation in its 2015 report –

WILLIAM YOUNG J:

Yes, but I really don't – I think we've got to look at smoking. I mean, it's probably a big enough issue in itself. I don't think we can say are they putting too much emphasis on smoking and not enough on drinking or eating or lack of exercise?

O'REGAN J:

We don't have any evidence on what they're doing about obesity anyway. I mean, there's nothing that we can…

MR FRANCOIS:

I'll leave it there, Your Honour. Now promote, but still, back to promoting healthy lifestyles. We don't have any evidence, when they introduced the ban

to prohibit all psychiatric patients from smoking cigarettes in the unit, of one person dying from passive smoking.

WILLIAM YOUNG J:
But you never would though. I mean, because people die of passive smoking as a result of inhalation of smoke over a lifetime.

MR FRANCOIS:
Well, but the purpose here is to prevent, is to promote the fact that, you know, we're promoting a healthy lifestyle and therefore we're going to remove this designated smoking room. We're going to remove it, even though it's got ventilation, because we don't want anybody to be affected by passive smoking. But no one was. However, people have committed suicide and people have lost their lives and people have been murdered because of this policy, because of the decommissioning of smoking rooms.

Now, Your Honours, I'm going to refer you to the WA, Western Australia Hansard which goes into the fact that total bans are a complete failure.

WILLIAM YOUNG J:
But that's just another view. I mean, I'm aware that – I think the Western Australian legislature abandoned the policy.

MR FRANCOIS:
They abandoned it.

WILLIAM YOUNG J:
But that's correct?

MR FRANCOIS:
Yes. But my friend says that they're all around the world.

WILLIAM YOUNG J:

But I think they – well, that's not – those aren't inconsistent propositions. I mean –

MR FRANCOIS:

Well, it doesn't exist in –

WILLIAM YOUNG J:

I don't think he was saying they're universal.

MR FRANCOIS:

What about Bradford? What about Bendigo?

WILLIAM YOUNG J:

Well, but look, a series of single instances isn't going to help.

MR FRANCOIS:

Anyway –

WILLIAM YOUNG J:

I would have been interested in a survey of jurisdictions or health districts as to what the policy was, but coming up with individuals, individual instances, probably isn't –

GLAZEBROOK J:

Either way, in fact.

WILLIAM YOUNG J:

– isn't going to come up, isn't going to be various, isn't going to prove much. We know from one of your affidavits that the Canterbury District Health Board doesn't have a no smoking policy, a complete ban on – so we know it's not universal but beyond that we don't – we've had an indication that most Health Boards have a no smoking policy but that's all we know.

MR FRANCOIS:

Yes, and we know that Your Honours are very interested in Dr Sharon Lawn's evidence where she says partial bans don't work. Well, I'm just countering that by pointing out to Your Honours that –

WILLIAM YOUNG J:

That there are places where there are partial bans.

MR FRANCOIS:

– that Western Australian parliamentarians, referring to scientific evidence, say that total bans don't work. Would you like me to refer that –

WILLIAM YOUNG J:

Well, I saw there was a letter from –

O'REGAN J:

This is a case about a breach of the Bill of Rights, not what the best medical judgement is. Why don't you just concentrate on your legal arguments?

MR FRANCOIS:

Well, I believe it is a breach of the Bill of Rights to – when somebody –

O'REGAN J:

I know that but –

MR FRANCOIS:

– when somebody's right to life is taken away in Western Australia and they recognise it and in this country we don't.

WILLIAM YOUNG J:

Well, do you –

O'REGAN J:

So are you suggesting we're required to follow a decision of the Western Australian Courts –

MR FRANCOIS:
Well –

O'REGAN J:
– or the Western Australian Parliament. I mean that's just, nobody has suggested that we have to follow any other decision, so just make your submissions on the merits of the case.

WILLIAM YOUNG J:
And we are aware that it's controversial. We are aware there are different views.

GLAZEBROOK J:
I think, Mr Francois, aren't you just countering the view that this is justified because a total ban is clearly thought to work universally in pointing out that there's controversy over that –

MR FRANCOIS:
Yes.

GLAZEBROOK J:
– and that's not necessarily what all clinicians –

MR FRANCOIS:
Yes.

GLAZEBROOK J:
– or all Parliamentarians think –

MR FRANCOIS:
That's true, that's right Your Honour –

GLAZEBROOK J:
– that's the point you're making, isn't it?

MR FRANCOIS:

It can't be –

WILLIAM YOUNG J:

I think we know that actually.

GLAZEBROOK J:

Yes.

MR FRANCOIS:

It can't be just accepted because my learned friend gets up and says it. Now just a technical point and that will be it. The point about the people in the mental health units that we're talking about, Waiatarau, Taharoto, the adult units, they, we're talking about the people who are subject to a compulsory treatment order. All of them are. You don't have to be in ICU – you have to be under a CTO to be in ICU, you have to be. To be in the open ward, you don't necessarily have to be under a compulsory treatment order because you can be informal, or voluntary. But here the argument on discrimination is about both sets of people in the ICU and the open ward are on compulsory treatment orders. They're under the same orders. We're not talking about the involuntary ones – sorry, the voluntary ones. They're both on it. It's the fact that the ones that are in the ICU are more severely incapacitated and they're the ones who have to go through all these complications and negative impacts of the policy. But the point is they are both under compulsory treatment orders.

Your Honour I think that concludes that. Those are my submissions.

WILLIAM YOUNG J:

Thank you Mr Francois. We'll take time to consider our judgment and deliver it in writing in due course.

COURT ADJOURNS: 4.03 PM