ORDER PROHIBITING PUBLICATION OF NAMES OR IDENTIFYING PARTICULARS OF THE APPLICANTS.

IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

I TE KŌTI MATUA O AOTEAROA
TE WHANGANUI-A-TARA ROHE

CIV-2021-485-509
[2021] NZHC 3012

UNDER	the Judicial Review Procedure Act 2016
IN THE MATTER	of an application for Judicial Review
BETWEEN	FOUR AVIATION SECURITY SERVICE EMPLOYEES Applicants
AND	MINISTER OF COVID-19 RESPONSE First Respondent
	ASSOCIATE MINISTER OF HEALTH Second Respondent
	ATTORNEY-GENERAL Third Respondent

Hearing: 21 and 22 October 2021

Appearances: S J Grey and K M Henry for the Applicants
A M Powell and K B Bell for the Respondents

Judgment: 8 November 2021

JUDGMENT OF COOKE J

Table of Contents

Background [4]
Protection of the applicants [21]
The relevant rights under the New Zealand Bill of Rights Act 1990 [26]
Which rights are engaged? [27]
How the Bill of Rights limits the exercise of power [38]
First ground of challenge – ultra vires [48]

An alternative meaning? [54]
Is the measure within s 11(1)(a)(v)? [59]
Does vaccination limit transmission? [64]
Other grounds of challenge [72]
Conclusion on ultra vires [76]
Is the Order consistent with the Bill of Rights? [78]
The Court's approach [80]
The justification for vaccination [90]
The nature of the harm [92]
Does vaccination suppress transmission? [100]
Other factors raised by the applicants [113]
Conclusion on legitimacy [124]
The applicants' challenges to the Minister's decision [130]
Conclusion [143]

[1] The applicants for judicial review are four former Aviation Security Service employees. They challenge an order made by the Minister for COVID-19 Response (the Minister) under the COVID-19 Public Health Response Act 2020 (the Act). The COVID-19 Public Health Response (Vaccinations) Order 2021 (the Order) requires aviation security workers who interact with arriving or transiting international travellers to be fully vaccinated.[1]

[2] For the reasons explained in their affidavits the applicants did not want to be vaccinated and have been dismissed from their employment as a consequence. They have proceedings relating to that dismissal before the Employment Relations Authority but in these proceedings they challenge the legality of the Order made by the Minister.

[3] A related judicial review proceeding was recently considered by Churchman J, who dismissed a challenge to the Order.[2] Initially this challenge was to be heard together with that challenge on the understanding that the applicants' statement of claim would be amended to have a more confined scope.[3] But the Court subsequently concluded that the applicants' case still involved broader factual assertions that could

1 COVID-19 Public Health Response (Vaccinations) Amendment Order 2021, Schedule 2, cl 7.
2 *GF v Minister of COVID-19 Response and Ors* [2021] NZHC 2526.
3 *GF v Minister of COVID-19 Response and Ors* [2021] NZHC 2337.

not be properly addressed with the other proceeding.[4] So this proceeding has been dealt with separately, albeit urgently.

Background

[4] In December 2019 cases of an unknown respiratory illness began to emerge in Wuhan, China. That illness has come to be known as the SARS-CoV-2 virus, or COVID-19. By 30 January 2020 the Director-General of the World Health Organisation (WHO) had declared the existence of the virus to be a Public Health Emergency of International Concern.

[5] New Zealand responded swiftly, with Cabinet granting powers to certain Ministers to allow them to decide New Zealand's response to the outbreak, including proposed border restrictions.[5] On 3 February 2020, border entry restrictions were placed on foreign nationals transiting through or traveling from mainland China.

[6] New Zealand recorded its first confirmed case of COVID-19 on 28 February 2020. On 11 March 2020 the Director-General of WHO declared the COVID-19 outbreak a global pandemic, citing its "alarming levels of spread and severity".[6] On that day there were reported to be more than 118,000 confirmed cases in 114 countries, and 4,291 people had lost their lives from the illness.[7] It was decided by an ad hoc Cabinet Committee that the Government should follow a "go hard, go early" strategy which would require "border restrictions, intense testing, aggressive contact tracing, and stringent self-isolation and quarantine".[8]

[7] On 21 March 2020 the Government introduced a four-tiered Alert Level system and placed New Zealand at Alert Level 2. Just three days later the number of confirmed COVID-19 cases in New Zealand exceeded 100. On 23 March, the Prime Minister announced that the country would move immediately to Alert Level 3, and

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4 *K, B, L and N v Minister of COVID-19 Response and Ors* [2021] NZHC 2396.

5 *Borrowdale v Director-General of Health* [2020] NZHC 2090 at [11]; see also *Borrowdale v Director-General of Health* [2021] NZCA 520 at [22]–[83] for a detailed background of events during the initial COVID-19 outbreak in New Zealand.

6 World Health Organisation "WHO Director-General's opening remarks at the media briefing on COVID-19 (media briefing, 11 March 2020)".

7 "WHO Director-General's opening remarks at the media briefing on COVID-19 – 11 March 2020", above n 6.

8 *Borrowdale v Director-General of Health,* above n 5, at [18].

would move to Alert Level 4 for a minimum of four weeks after 48 hours. This marked New Zealand's first nationwide lockdown. The Prime Minister subsequently issued an Epidemic Notice under s 5 of the Epidemic Preparedness Act 2006. A State of National Emergency was declared on 25 March under s 66 of the Civil Defence Emergency Act 2002.

[8] The Director-General of Health also invoked powers under s 70 of the Health Act 1956 to impose measures. The first of the orders required all premises to be closed and forbade amusement or recreational congregations in outdoor settings. As cases began to rise another order was made which required "all persons to be isolated or quarantined by remaining at their current place of residence, except as permitted for essential personal movement, and to maintain physical distancing".[9] A third order subsequently replaced the first two orders, imposing largely the same restrictions

[9] In *Borrowdale v Director-General of Health* the Court responded to a challenge to the lawfulness of these restrictions. That challenge related to matters arising out of the three orders made by the Director-General under s 70 of the Health Act, as summarised above. In its assessment of the s 70 powers, a full bench of the High Court considered the overall context of the lockdown, including a timeline of the spread of COVID-19 and the steps taken to respond, as well as the background to s 70. The challenges to the orders were rejected as the Court found that the Director-General was entitled to exercise the powers. However, the Court held that while the requirement for New Zealanders to stay home for the first nine days of lockdown was justified, it was nevertheless unlawful, because the limitations it placed on the rights protected by the New Zealand Bill of Rights Act 1990 were not prescribed by law. A declaration was accordingly made.[10] This decision has since been unsuccessfully appealed to the Court of Appeal.[11]

[10] The alert level system was largely effective against the initial outbreak. By 8 June 2020 there were no more active cases of COVID-19 in New Zealand and subsequent outbreaks were quickly contained. Throughout the pandemic

9 At [29].
10 *Borrowdale v Director-General of Health,* above n 5, at [240].
11 *Borrowdale v Director-General of Health* [2021] NZCA 520.

New Zealand has employed what has been referred to as the "elimination strategy", shifting between alert levels to respond to the COVID-19 threat in the community with the object of reducing the number of cases to zero.

[11] As this Court observed in *Borrowdale,* however, the powers under s 70 of the Health Act were "intended to facilitate an immediate and urgent response to a public health crisis", so they could not be regarded as providing the framework for a longer-term response.[12] The Act was accordingly enacted to provide a legal framework for responding specifically to COVID-19. It was enacted under urgency in May 2020. The Bill was introduced on 12 May and went through the Parliamentary process within a day, receiving assent on 13 May.

[12] The Act sets up a regime under which orders can be made to fulfil the purposes set out in s 4. These purposes are directed to preventing and limiting the risk of an outbreak or spread of COVID-19 and its adverse effects. Orders can be made by the Minister under s 9, or by the Director-General under s 10. The type of orders that can be made are set out in s 11 — for example orders can be made that persons refrain from travelling to or from any specified area,[13] or be isolated or quarantined in any specified way or place.[14] The Order made under s 11(1)(a)(v) that is challenged here required specified activities (border work) only be carried out in compliance with specified measures (that the border workers be vaccinated). Section 12 elaborates on what an order can or cannot do — for example under s 12(2)(a) an order may not be specific to an individual, and under s 12(2)(d) an order may not apply to Parliamentary precincts or any premises used as a Court.

[13] There are a number of provisions that put limits on the exercise of the powers to make orders. Under the purpose provision orders must be "proportionate".[15] The prerequisites for the Minister making an order include a requirement for the Minister to have regard to advice from the Director-General about the risks of outbreak or

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12 *Borrowdale v Director-General of Health*, above n 5, at [102].
13 COVID-19 Public Health Response Act 2020, s 11(1)(a)(iv).
14 Section 11(1)(a)(vi).
15 Section 4(c).

spread, and the nature and extent of measures that are appropriate to address those risks.[16] In outlining the matters that must be taken into account s 9(1) also provides:

> **9 Minister may make COVID-19 orders**
>
> (1) The Minister may make a COVID-19 order in accordance with the following provisions:
>
> …
>
> (ba) the Minister must be satisfied that the order does not limit or is a justified limit on the rights and freedoms in the New Zealand Bill in Rights Act 1990.
>
> …

[14] Section 13 confirms the validity of an order notwithstanding other legislation, expressly recording that such validity does not affect the application in the Bill of Rights, and preserving the right to bring legal proceedings in relation to orders.[17] There are requirements for publication, and addressing the duration of such orders, including an obligation that the Minister and Director-General must keep them "under review".[18] There are powers to extend the period of time of orders under s 15, but under s 16 an order made by the Minister is revoked unless it is approved by resolution by the House of Representatives within 10 sitting days if the House is sitting, or 60 days after the date the Order is made, whichever is later. Under s 17 an order must be presented to the House of Representatives as soon as possible. Certain ancillary provisions, including offence provisions are set out in the balance of the Act, and there are provisions concerning cost recovery in relation to managed isolation facilities.

[15] Overall the Act establishes powers to make orders with significant restrictive effect or impact for the purpose of addressing the risks of an outbreak or the spread of COVID-19, with significant limits or restrictions on the exercise of those powers.

[16] The measures challenged in this case involve a requirement for certain workers to be vaccinated. Following successful international efforts to develop an effective vaccine, in October 2020 the Government announced that it had agreed to buy 1.5

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[16] Section 9(1)(a).
[17] Section 13(2) and (3).
[18] Section 14(5).

million doses of the Pfizer-BioNTech vaccine. In January 2021 it announced that vaccinations would be available to the public by mid-year, and by February the vaccine was provisionally approved by Medsafe subject to numerous conditions. The vaccine was then formally approved for persons aged 16 years and older, later approved for those aged 12 years and older. By March it was announced that the Government had purchased enough of the vaccine for every New Zealander. At the time of this judgment the Government is aiming for a 90 per cent vaccination rate in order to ease restrictions imposed in response to an outbreak of the Delta variant of COVID-19 in August of 2021.

[17] The Court heard an application for interim orders to prevent or halt the vaccine being rolled out in *Nga Kaitiaki Tuku Iho Medical Action Society Inc v Minister of Health & Ors*.[19] The proceedings challenged the legality provisional consent given for the vaccine under s 23 of the Medicines Act 1981. The Court considered the provisional consent process in detail and declined the application for interim relief, whilst recording a concern that provisional consent designed for making medicines available for a limited class of patients was being used for widespread availability.

[18] Consideration was given to making the Order challenged in this case from March 2021. On 18 March 2021 the Minister made a decision that Cabinet approval should be sought to amend the Act "so that it explicitly allows an order to be made requiring specified high risk roles at the border only to be carried out by vaccinated workers and then issue an order under the Act". He expressly decided not to make an order under the Act without the legislative amendment at this time. By 16 April 2021 the position had changed and the Minister decided to make the Order without first seeking amendment of the Act. The respondents' affidavits do not provide an explanation for that change, although a perceived need to act with urgency may well have been one of the factors.

[19] The Order challenged in these proceedings became enforceable on 30 April 2021, and an amended version was made on 14 July 2021. The purpose of the Order is to require most border workers to be vaccinated in order to "prevent, and limit the

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19 *Nga Kaitiaki Tuku Iho Medical Action Society Inc v Minister of Health & Ors* [2021] NZHC 1107.

risk of, the outbreak or spread of COVID-19".[20] The difference between the original Order and the Order as amended is that the former applied only to work undertaken in managed isolation and quarantine facilities and by certain Government officials in affected workplaces. The effect of the Order as amended is to expand the group of workers that need to be vaccinated to include those in the position of the applicants. The amendment also gives the Minister the power to grant exemptions.

[20] In *GF v Minister of COVID-19 Response* Churchman J considered a challenge to the lawfulness of the Order by an applicant who was previously an employee of the New Zealand Customs Service, and whose employment was terminated as a result of the Order. His Honour characterised the case as addressing the "intersection between the legislation designed to achieve the public benefit of preventing or limiting the risk of the spread of the COVID-19 virus and the private interests inherent in an employee relationship".[21] The Court considered the context of the Order in its assessment. It was ultimately held that the infringement of rights under ss 11 (right to refuse to undergo medical treatment) and 19 (freedom from discrimination) of the New Zealand Bill of Rights Act was no more than was justified in a free and democratic society. His Honour also observed it was not for the Court in judicial review proceedings to second-guess policy decisions made by the Government where economic and social factors had clearly been considered.[22] So the Order was found not to be ultra vires the Act, nor irrational.

Protection of the applicants

[21] There is a preliminary point to make in relation to the applicants, and those in their position.

[22] The COVID-19 pandemic, and the Governmental response to it, has had a very significant impact on the lives of all who live in New Zealand. Restrictive measures have been introduced to seek to address the threat to New Zealand communities arising from the virus. It has dominated public discourse, particularly when measures

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20 COVID-19 Public Health Response (Vaccinations) Order 2021, cl 3.
21 *GF v Minister of COVID-19 Response & Ors,* above n 2, at [1].
22 At [58].

have been most restrictive, and the threat of the virus has seemed to be the most concerning.

[23] In recent times there has been a very strong emphasis on vaccination, and the benefits of as many New Zealanders as possible being vaccinated for the overall public good. It is a matter of observation that in public discourse those who are not in favour of vaccination can be subject to criticism, and at times public condemnation. Within that environment the Court plays an important role. The issue that is raised by the applicants in this challenge is clearly a legitimate one to raise with the Court. A fundamental right in the Bill of Rights is being limited. In their affidavits the applicants have explained why they did not wish to be vaccinated, and the reasons that they have put forward are understandable, particularly in specific cases. They have lost their employment as a consequence of the challenged measures. It may also be appropriate to record that the applicants have been on the front line in the public health response to COVID-19, including when deployed in managed isolation facilities, putting themselves at risk for the public benefit. Their evidence also describes the difficult circumstances they have had to face, including in those facilities. They should not be thought of as any less committed to the community than any other New Zealander.

[24] The function of the Court is to ensure that the rights of minority groups are properly protected when measures such as those in issue are implemented, including measures that appear to have widespread public support. The Court must ensure that the rule of law is observed. There should also be no doubt that persons in the position of the applicants have the right to access the Court to challenge the legitimacy of the measures imposed. The right of access to the Court is fundamental to the very legitimacy of the measures implemented.

[25] In that context I have granted an application that the applicants' identities be suppressed. This order is made under the inherent jurisdiction in order to avoid the unnecessary personal identification and criticism of the applicants. I accept that there is a significant risk of publicity if such an order is not made and that this could cause hardship in the current environment. I also accept that such an order is appropriate to emphasise the importance of access to the Court for those adversely affected by

measures that are perceived to be in the wider public interest. For these reasons that order was made notwithstanding the importance of open justice.[23]

The relevant rights under the New Zealand Bill of Rights Act 1990

[26] The rights of the applicants under the New Zealand Bill of Rights Act 1990 (the Bill of Rights) are fundamental to this challenge. But it is important to identify which rights are relevant, and how they are relevant. Both questions are in issue.

Which rights are engaged?

[27] There was a difference between the parties over the rights under the Bill of Rights that are affected by the Order.

[28] The respondents accept that the applicants' rights under s 11 of the Bill of Rights — the right of everyone to refuse to undergo any medical treatment — are limited by the Order. That was recognised when the Order was made, and was accepted in argument before the Court. The respondents say, however, that this limitation is a reasonable limit prescribed by law that can be demonstrably justified in a free and democratic society in accordance with s 5 of the Bill of Rights.

[29] I agree that the Order limits the applicants' rights under s 11. Vaccination is a medical treatment. Whilst persons in the position of the applicants are not being forcibly treated in the sense that they can decline to be vaccinated, they are required to be vaccinated as a condition of their employment and to decline to do so can, and has, led to termination. A right does not need to be taken away in its entirety before it is regarded as having been limited. A limitation short of removal is still a limitation. A similar issue arose in *New Health New Zealand Inc v South Taranaki District Council* which concerned the fluoridation of community water supplies.[24] The Supreme Court held that when the water supply was fluoridated those who lived and

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[23] Initially the interim order extended to preventing publicity of the fact that these workers were based at Christchurch, but I subsequently concluded that it is not inappropriate to disclose that location.

[24] *New Health New Zealand Inc v South Taranaki District Council* [2018] NZSC 59, [2018] 1 NZLR 948.

worked in the affected area had no practical option but to ingest the fluoride that had been added to the water, and that the right under s 11 was accordingly being limited.[25]

[30] It is a matter of degree whether practical pressure to undergo a medical treatment will be taken to have limited the right to refuse that treatment. Here the level of pressure is significant and amounts to coercion. The employees are forced to be vaccinated or potentially lose their jobs. This involves both economic and social pressure. I accept that the right is accordingly engaged, and that it is limited by the Order. The key question in this case is whether this limitation is demonstrably justified.

[31] Ms Grey argued that the Order also limited other fundamental rights under the Bill of Rights, including:

(a) the right not to be deprived of life under s 8;

(b) the right of freedom of thought conscience and religion under s 13;

(c) the right of freedom of expression under s 14; and

(d) the right not to be subjected to medical or scientific experimentation under s 10.

The argument that those rights are limited by the Order can largely be rejected out of hand. Of these only the argument that the right under s 10 not to be subjected to medical or scientific experimentation is engaged justifies closer analysis.

[32] The primary basis for arguing that this right is limited by the Order is that the consent to the Pfizer vaccine under the Medicines Act 1981 has only been granted on a provisional basis, and it is subject to a number of conditions. Ms Grey argued that vaccination amounted to an experimental treatment on the basis that a number of further steps are required under the provisional consent and a number of these matters would normally have been attended to before a full consent was granted.

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[25] At [97]–[100], [172] and [212]–[213].

[33] I do not accept this argument for two reasons.

[34] First, as Mr Powell submitted, the concept of experimentation in s 10 requires an intervention which aims to lead to a new standard of treatment or to advance knowledge. By contrast, medical treatment is characterised by its therapeutic aim, and connotes an existing measure used by healthcare professionals in treating or preventing illness.[26] The vaccine is a new treatment for a new virus. But it is plain that the vaccine has been approved and used here for therapeutic, not experimental, purposes.

[35] Secondly, I do not accept Ms Grey's submission that the fact that the consent given to the Pfizer vaccine was provisional means that it is experimental. Evidence was provided by Christopher James, the Group Manager of New Zealand Medicines at Medsafe. His evidence establishes that the vaccine has been through a rigorous assessment of its efficacy and safety. To require it to go through the procedures that would be required for full consent would take time, and there was an urgent need to make the vaccine available once it had been assessed as safe and effective. This does not mean that the vaccine is experimental, or that there is material concern about its availability. As Ellis J held when declining an application for an interim orders in *Nga Kaitiaki Tuku Iho Medical Action Society Inc v Minister of Health and Ors*.[27]

> … it must be recognised that the process gone through here was not an orthodox provisional consent process—it went above and beyond. Although s 23 applications are not required to provide the s 21 particulars about the safety and efficacy of the vaccine, it is clear that those particulars were, in fact, provided by Pfizer, in part (no doubt) because an application for full consent was also made. And it is difficult to see how the assessment process could, in the circumstances, have been more thorough. As set out above, Mr James' evidence makes it clear that there were a number of layers of reflection and review in addition to those that would ordinarily be expected in a provisional consent assessment. The risks with which s 23 is concerned—and the reason for the restrictions around granting a provisional consent—have therefore been considerably diminished.

[36] I agree with that assessment. The only issue was that at the time of that application provisional consents were only granted for medicines used by a limited

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26 *Taylor v Attorney-General* HC Auckland, CIV-2010-485-2226, 19 July 2011 at [31]; E Deutsh "*Medical Experimentation: International Rules and Practice*" (1989) 19 VUWLR 1 at 1.

27 *Nga Kaitiaki Tuku Iho Medical Action Society Inc v Minister of Health and Ors*, above n 19, at [69].

number of patients, whereas here the vaccine was to be rolled out universally to those over 16.[28] But that issue was resolved by Parliament immediately after the interim relief decision.[29] In *GF v Minister of COVID-19 Response* Churchman J concluded that the availability of the vaccine after provisional approval for use in New Zealand was not equivalent to medical experimentation because that approval was granted on the basis of "the provision of information of similar comprehensiveness to that required for full approval".[30] For similar reasons I do not accept that the s 10 right is engaged by the Order.

[37] Although it was not relied upon by the applicants in submissions, there is a further right under the Bill of Rights that may well have been limited by the Order. As the respondents assessed at the time, the right under s 19 to be free from the grounds of discrimination set out in the Human Rights Act 1993 may be engaged. The Order does not treat different groups differently on a prohibited ground. But some members of the affected group may not be able to be vaccinated because of illness or disability, or potentially religious beliefs. Difficult issues may arise with such a suggestion, including whether a particular set of beliefs held by a person falls within a prohibited ground of discrimination. In order to address whether such rights are engaged the prohibited ground of discrimination would need to be raised by an applicant for judicial review. In the absence of a particular ground of discrimination being raised by the applicants, and the consequent absence of relevant evidence and argument, I do not address the matter further.[31]

How the Bill of Rights limits the exercise of power

[38] The second question relates to how the Bill of Rights limits the exercise of statutory powers such as, here, the power to make orders.

[39] In advancing the challenge to the legality of the Order, the applicants pleaded that the decisions were unlawful for three reasons. The first cause of action was that the Order was unlawful because it was made outside the empowering provisions in

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28 At [64]–[67].
29 See Medicines Amendment Act 2021, s 23(1).
30 *GF v Minister of COVID-19 Response*, above n 2 at [47].
31 See generally *GF v Minister of COVID-19 Response*, above n 2, at [73], [87]–[93].

ss 9 and 11 of the Act. In advancing that argument the applicants contended that the empowering provision needed to be interpreted consistently with the Bill of Rights in the way outlined by the Supreme Court in *R v Hansen*.[32] The second and third causes of action were challenges to the decision of the Minister to make the order on conventional review grounds — failure to take into account mandatory relevant considerations, and irrationality. Both involved the Bill of Rights providing part of the foundation for the mandatory relevant considerations and the alleged irrational decision-making.

[40] But there is a more direct route by which the Bill of Rights controls the making of orders under the Act. In the line of authority including *Drew v Attorney-General*, *Cropp v Judicial Committee*, *Zaoui v Attorney-General (No 2)*, *Dotcom v Attorney-General* and *New Health New Zealand v South Taranaki District Council* the Supreme Court and Court of Appeal have held that subordinate legislation that is inconsistent with the Bill of Rights cannot be promulgated in the absence of express provision in the empowering legislation to the contrary.[33] As Glazebrook J captured it in *New Health* "[t]here is a principle of interpretation that any general power is assumed to be subject to the Bill of Rights Act".[34]

[41] There is nothing in the present Act that excludes that principle. Indeed the indications are to the contrary. Section 13(1) prevents orders made under the Act from being invalidated for certain specified reasons, but in accordance with subsection (2) this "does not limit or affect the application of the New Zealand Bill of Rights Act 1990". And under s 9(1)(ba) the Minister may make an order only if he is satisfied that it does not limit or is a justified limit on the rights and freedoms in the Bill of Rights. These provisions confirm rather than rebut the presumption that any order made under the Act must be consistent with the Bill of Rights. It follows that any order that is not consistent with the Bill of Rights is invalid. It is therefore not necessary to establish other grounds of invalidity, such as irrationality or a failure to

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32 *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1.

33 *Drew v Attorney-General* [2002] 1 NZLR 58 (CA); *Cropp v Judicial Committee* [2008] NZSC 46, [2008] 3 NZLR 774; *Zaoui v Attorney-General (No 2)* [2005] NZSC 38, [2006] 1 NZLR 289; *Dotcom v Attorney-General* [2014] NZSC 199, [2015] 1 NZLR 745; and *New Health New Zealand Inc v South Taranaki District Council*, above n 24 at [294]–[297].

34 *New Health New Zealand Inc v South Taranaki District Council*, above n 24, at [175].

take into account particular considerations if the decision is made inconsistently with the Bill of Rights, in order to have the Order set aside on this basis.

[42] This is not how the applicants' challenge has been formulated. But it is an unavoidable implication of the arguments that have been advanced. It effectively eclipses many of the arguments that have been advanced based on the Bill of Rights, or otherwise is an answer to them.

[43] In those circumstances I raised at the hearing that it was necessary for the Court to address the unarticulated argument that the Order was invalid for being inconsistent with the rights in the Bill of Rights, and in particular is invalid because measures in the Order involved an unjustified limit on the right in s 11. There did not appear to be any significant prejudice involved in my allowing this argument to be part of the applicants' case. Indeed it appeared to have been anticipated in the respondents' written submissions. There was one procedural implication, however. The applicants' evidence had not provided a great deal of material directly addressed to the question whether the limit on the s 11 right was demonstrably justified. For example there was no expert evidence from an epidemiologist, or other person having expertise in the issues which are central to addressing the justified limitation question. An affidavit had been provided by Dr Sophie Febery, a general practitioner from Methven who has a particular interest in the issues that have arisen around vaccination, and who has conducted personal research into the issues. She did not seek to qualify herself as an expert in this field, and largely provided evidence of fact. At the beginning of her oral submissions Ms Grey also indicated that as a consequence of Dr Febery's personal decisions her ability to continue work as a general practitioner was now in doubt, fairly acknowledged that such implications might lessen the independence of her opinion evidence. Although I doubt that Dr Febery's opinions can be regarded as having weight, I nevertheless accept the evidence as diligently researched material from a GP with a close personal interest in the issues. The publications and papers she has annexed can also be taken into account.

[44] The procedural difficulty emerged from the fact that, only in reply, Dr Febery put in evidence a series of publications and papers going to issues that had been addressed in the respondents' affidavits, and particularly the evidence from the

Director-General of Health, Dr Ashley Bloomfield, and the Ministry of Health Chief Science Adviser, Dr Ian Town. Given that this material only emerged in reply, and that the applicants' case had not squarely challenged the Order on the more straightforward basis that I have outlined above, I gave the respondents leave to file a further affidavit addressing Dr Febery's affidavit in reply. I also gave Ms Grey the opportunity to file written submissions responding to that further affidavit.[35]

[45] Dr Town duly filed a further affidavit responding to Dr Febery's evidence, and the applicants filed submissions responding to that affidavit. But the applicants also filed a further new affidavit from an epidemiologist, Dr Simon Thornley. This affidavit took issue with Dr Town's evidence. Most significantly, it amounted to expert evidence from an epidemiologist directed to the matters at issue in this case.

[46] The applicants did not seek leave to file this evidence. Its filing is procedurally problematic because evidence of this kind going to the legitimacy of the Order should have been filed with the initial affidavits relied on by the applicants. At the very least, leave to file such evidence should have been sought from the Court when I discussed with counsel the procedural steps involved in the respondents providing further evidence responding to Dr Febery's reply evidence, or then at the telephone conference after the hearing leading to the confirmation of the directions in my minute of 27 October.

[47] I have considered putting in place yet further procedures to give the respondents a fair opportunity to respond to the evidence from Dr Thornley, which would likely involve a further hearing, and may also have involved cross-examination of experts to resolve what is potentially a contest of expert evidence. But in the end I have decided not to take that course. There is a degree of urgency to this proceeding, and there are limits to the Court's ability to resolve issues of contested expert evidence. There needs to be an end to receiving evidence taken after the hearing has concluded. I will accordingly take Dr Thornley's evidence into account, but recognising that it has only been filed after the hearing, and in a manner that has meant that the respondents have not had the opportunity to respond to it.

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[35] After the hearing, and by minute of 27 October I also indicated that evidence emerging after the Order was made could be relevant and gave further procedural directions accordingly.

First ground of challenge – ultra vires

[48] The applicants' first ground of challenge is that the Order is not authorised by the empowering provisions contained in ss 9 and 11 of the Act. Sections 9 and 11 provide:

> **9 Minister may make COVID-19 orders**
>
> (1) The Minister may make a COVID-19 order in accordance with the following provisions:
>
> (a) the Minister must have had regard to advice from the Director-General about—
>
> (i) the risks of the outbreak or spread of COVID-19; and
>
> (ii) the nature and extent of measures (whether voluntary or enforceable) that are appropriate to address those risks; and
>
> (b) the Minister may have had regard to any decision by the Government on the level of public health measures appropriate to respond to those risks and avoid, mitigate, or remedy the effects of the outbreak or spread of COVID-19 (which decision may have taken into account any social, economic, or other factors); and
>
> (ba) the Minister must be satisfied that the order does not limit or is a justified limit on the rights and freedoms in the New Zealand Bill of Rights Act 1990; and
>
> (c) the Minister—
>
> (i) must have consulted the Prime Minister, the Minister of Justice, and the Minister of Health; and
>
> (ii) may have consulted any other Minister that the Minister (as defined in this Act) thinks fit; and
>
> (d) before making the order, the Minister must be satisfied that the order is appropriate to achieve the purpose of this Act.
>
> (2) Nothing in this section requires the Minister to receive specific advice from the Director-General about the content of a proposed order or proposal to amend, extend, or revoke an order.
>
> …
>
> **11 Orders that can be made under this Act**
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> (1) The Minister or Director-General may in accordance with section 9 or 10 (as the case may be) make an order under this section for 1 or more of the following purposes:

(a) to require persons to refrain from taking any specified actions that contribute or are likely to contribute to the risk of the outbreak or spread of COVID-19, or require persons to take any specified actions, or comply with any specified measures, that contribute or are likely to contribute to preventing the risk of the outbreak or spread of COVID-19, including (without limitation) requiring persons to do any of the following:

(i) stay in any specified place or refrain from going to any specified place:

(ii) refrain from associating with specified persons:

(iii) stay physically distant from any persons in any specified way:

(iv) refrain from travelling to or from any specified area:

(v) refrain from carrying out specified activities (for example, business activities involving close personal contact) or require specified activities to be carried out only in any specified way or in compliance with specified measures:

(vi) be isolated or quarantined in any specified place or in any specified way:

(vii) refrain from participating in gatherings of any specified kind, in any specified place, or in specified circumstances:

(viii) report for and undergo a medical examination or testing of any kind, and at any place or time, specified and in any specified way or specified circumstances:

(ix) provide, in specified circumstances or in any specified way, any information necessary for the purpose of contact tracing:

(x) satisfy any specified criteria before entering New Zealand from a place outside New Zealand, which may include being registered to enter an MIQF on arrival in New Zealand:

(b) in relation to any places, premises, crafts, vehicles, animals, or other things, to require specified actions to be taken, require compliance with any specified measures, or impose specified prohibitions that contribute or are likely to contribute to preventing the risk of the outbreak or spread of COVID-19, including (without limitation) any of the following:

(i) require things to be closed or only open if specified measures are complied with:

(ii) prohibit things from entering any port or place, or permit the entry of things into any port or place only if specified measures are complied with:

(iii) prohibit gatherings of any specified kind in any specified places or premises, or in any specified circumstances:

(iv) require things to be isolated, quarantined, or disinfected in any specified way or specified circumstances:

(v) require the testing of things in any specified way or specified circumstances.

(2) An order made by the Minister may specify which breaches of an order made by the Minister or the Director-General are infringement offences for the purposes of section 26(3).

(3) For the purpose of this section and section 12, things means any things mentioned in subsection (1)(b), including places, premises, ports, crafts, vehicles, and animals.

[49] The Order that has been made under s 11 provides:

7 Duty of affected person not to carry out certain work unless vaccinated

An affected person must not carry out certain work unless they are vaccinated.

[50] "Vaccinated" is defined to include receipt of all doses of the COVID-19 vaccines specified in Schedule 3 in the Order as amended. "Certain work" is defined to be the work the person carries out as specified in Schedule 2, and Schedule 2 includes the following:

Part 3: Groups in relation to affected airports

3.1 All airside workers (other than excluded airport persons)

3.2 All landside workers who interact with international arriving or international transiting passengers (other than those arriving on QFT flights)

[51] Ms Grey argued that this requirement to vaccinate did not fall within s 11(1)(a)(viii), and that no wider power to make the Order could be implied. I accept her submission is right in both respects — the Order does not involve medical examination or testing as contemplated by subsection (viii), and there can be no suggestion of an implied power to make orders. Mr Powell did not suggest otherwise.

[52] What Ms Grey's written submissions did not address, and what was explained in Mr Powell's written submissions, was that the Order had been made under s 11(1)(a)(v) — the power to make an order requiring persons to refrain from carrying out specified activities (for example, business activities involving close personal contact) or to require specified activities to be carried out only in any specified way or in compliance with specified measures.

[53] There are three issues that emerge from the exercise of s 11(1)(a)(v) to make the Order, although they were not all squarely addressed in the applicants' written submissions. They relate to the proper interpretation of the empowering provisions, whether the measure falls within s 11(1)(a)(v), and the matter of transmission.

An alternative meaning?

[54] First, a significant aspect of Ms Grey's submissions were directed to interpreting the empowering provision so that it was not inconsistent with the rights in the Bill of Rights, albeit focused on s 11(1)(a)(viii) and the broader category of rights she contended were in issue. She nevertheless submitted that the approach to interpretation explained by the Supreme Court in *R v Hansen* should be applied, including the requirement to adopt an alternative interpretation of the provision that was consistent with the rights in the Bill of Rights as required by s 6.[36]

[55] There is an answer to that submission. As indicated above, there is a well-established principle that a power to make subordinate legislation cannot be exercised in a manner that is inconsistent with the Bill of Rights unless Parliament has clearly legislated in a way that permits subordinate legislation to be inconsistent.[37] So in *New Health* the Supreme Court held that it would not be lawful for local authorities to exercise a statutory power to fluoridate water if this involved an unjustified limit on the right to refuse medical treatment. Such non-consistent measures could not be authorised by the empowering provision in the Local Government Act 2002. The ultimate issue accordingly became whether use of that power to fluoridate community

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[36] *R v Hansen*, above n 32.
[37] See [40] above.

water supplies was a justified limit on the s 11 right. If it was not, the exercise of that power would not have been lawful.[38]

[56] The position is the same here. The empowering provisions in the Act do not need to be reinterpreted to make them consistent with the rights in the Bill of Rights, since any order made under ss 9 and 11 of the Act cannot be inconsistent with the Bill of Rights. There is an implied limitation on, or proviso to, the empowering provisions that is equivalent to them having concluding words to the effect "provided that no order may be made that is not consistent with the New Zealand Bill of Rights Act 1990". That is the effect of the authorities I referred to at [40] above.

[57] There is accordingly no need, or licence, to find an alternative interpretation of the empowering provision in the way described by the Supreme Court in *R v Hansen*, or for reading down the provisions in the way more recently described by the Supreme Court in *Daniel Clinton Fitzgerald v R*.[39] That means that what might be described as the normal approach to interpreting the empowering provision should be adopted, which focuses on the text in light of its purpose. That is what the majority of the Supreme Court did in *New Health* when interpreting the empowering provisions in the Local Government Act in relation to fluoridation. This does not mean that appropriate consideration is not given to factors such as the significant impact that a requirement to vaccinate may have for the affected persons, or the lack of direct reference to vaccination in the empowering provision. It is just that those issues are addressed without the additional Bill of Rights dimension. The Bill of Rights question is a separate, and self-standing one which I address below.

[58] Had it been appropriate to apply the kind of approach referred to in *R v Hansen* it would also still have been necessary to identify whether the limit on the s 11 right was demonstrably justified under s 5. On the approach in *Hansen*, only if the limit

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38 The Court's reasoning divided on this issue. Elias CJ held that the power to fluoridate could not be seen to be authorised by the empowering provision – [219]. The majority reached the opposite conclusion. William Young J concluded that fluoridation did not engage the s 11 right – [178], but the majority reached the opposite conclusion. O'Regan and Ellen France JJ then held that fluoridation amounted to a justified limit on the s 11 right in accordance with s 5 – [144]. Glazebrook J agreed that this was the required analysis, but concluded that the answer depended on local conditions and that this was not strictly before the Court – [176].

39 *Daniel Clinton Fitzgerald v R* [2021] NZSC 131.

had not been demonstrably justified would the search for an alternative meaning become necessary.[40] I note that the Court of Appeal in *Borrowdale* considered compliance with the Bill of Rights by applying the *Hansen* approach in relation to the empowering provision under the Health Act, whilst noting that it was not the only approach to interpretation in light of the Bill of Rights.[41] The particular approach adopted should not make a difference to the ultimate outcome, however. In *Borrowdale* the Court of Appeal concluded that the measures were demonstrably justified.[42] In my view it is more appropriate to address that question directly in a case such as the present.

Is the measure within s 11(1)(a)(v)?

[59] The next question is whether the Order falls within s 11(1)(a)(v).

[60] Ms Grey submitted that it was significant that s 11 of the Act made no reference to vaccination at all. If Parliament had intended to allow the Minister to exercise powers to compel vaccination, the Act would have specifically stated so. Vaccination is a significant measure, and an order requiring employees to be vaccinated to be permitted to continue performing the functions contemplated by their employment is the type of measure that would require express reference within the empowering provision. This is similar in kind to the argument accepted by Elias CJ, but rejected by the majority of the Supreme Court, in *New Health*.[43]

[61] I accept that there is force in this submission, but I ultimately do not accept it. Section 11(1)(a)(v) is specific in being directed to particular activities, and gives the example of activities involving close personal contact. It then contemplates orders that those activities only be undertaken "in any specified way or in compliance with specified measures". It seems to me that "activities" must include those undertaken by employees in certain occupations. Moreover the "way" those activities are to be conducted, and the "measures" that must be complied with, are deliberately formulated by Parliament in reasonably open-ended terms. The limits on the scope of

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40 *R v Hansen*, above n 32, at [89]–[90].
41 *Borrowdale v Director-General of Health*, above n 5, at [134]–[141] and [142]–[163].
42 At [162].
43 *New Health New Zealand Inc v South Taranaki District Council*, above n 24, at [219].

the exercise of such power arise from the requirement under the first part of s 11(1)(a) that the actions must be likely to contribute to preventing the risk of the outbreak or spread of COVID-19. Provided that the "way" of undertaking the activities, or the "measures" specified for their undertaking, are likely to contribute to preventing the risk of outbreak or spread, they are within the empowering provision and can therefore be regarded as properly imposed.

[62] The fact that the "specified measures" with which persons can be required to comply are not referred to elsewhere in s 11 does not seem to me to be decisive. For example, there is no reference in s 11 to a requirement to wear personal protective equipment (PPE). Yet an order requiring people who conduct particular activities to wear PPE seems to me to be the kind of measure that is obviously within the empowering provision. It seems to me that the same is true for vaccination. Provided that vaccination is likely to contribute to preventing the risk of an outbreak or spread of COVID-19 it seems to me available as a specified measure that can be imposed for the carrying out of a specified activity under s 11(1)(a)(v). I see no reason to give the words "specified way" or "specified measures" a narrow interpretation — they should be interpreted in light of their purpose. The purposes of the Act are set out in s 4, and the very first purpose provides:

> **4 Purpose**
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> The purpose of this Act is to support a public health response to COVID-19 that—
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> (a) prevents, and limits the risk of, the outbreak or spread of COVID-19 (taking into account the infectious nature and potential for asymptomatic transmission of COVID-19); and
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> …

[63] For these reasons the measures specified in the Order are within the empowering provision if they meet the requirements for making the order. No additional interpretive constraint is necessary or appropriate here.

Does vaccination limit transmission?

[64] The final question is an evidential one. Did the evidence before the Minister establish the prerequisite in s 11(1)(a) that vaccination of those workers would

contribute or be likely to contribute to preventing the risk of the outbreak or spread of COVID-19? The means by which vaccination is said to so reduce the risk of the outbreak or spread of COVID-19 is by reducing the transmissibility of the disease. Workers who are most likely to be exposed to the virus, such as those working at the border, have been required to be vaccinated on the basis that they will be less likely to transmit an infection to others in the community.

[65] The parties' argument in relation to the evidence about transmission was not directed to the prerequisite for the Minister's making of the Order which arises from the words "contribute or are likely to contribute to preventing the risk of the outbreak or spread of COVID-19" in s 11(1)(a). But, again, it is an unavoidable implication of the respondents' arguments as to the evidential foundation of the Order, so it seems to me that I need to address it.

[66] For two related reasons I conclude that the s 11(1)(a) "contribute or likely to contribute to preventing the risk of the outbreak or spread of COVID-19" prerequisite was plainly satisfied.

[67] I accept, for reasons that I will explain in greater detail below, that there is a degree of evidential uncertainty as to the effectiveness of vaccination in reducing the likelihood of transmission of the Delta variant of COVID-19.[44] The evidence establishes that it clearly does reduce the transmissibility of the earlier variants of COVID-19. But at the time that the Order was made, evidence in the form of scientific studies proving that it also reduced the transmissibility of the more contagious Delta variant was not yet available. However, neither the Minister nor the Court are obliged to confine their consideration on the potential for vaccination to inhibit transmission to what can be established by way of scientific proof. Any such limitation would likely lead to measures being taken too late. For the reasons I explain below I am satisfied that vaccination is likely to contribute to reducing the risk of transmission of the Delta variant. The Minister explained in his evidence that he was of this view when the Order was made, and I accept there was a proper evidential foundation for that conclusion.

[44] At [100]–[112] below.

[68] In any event the second point is that the statutory prerequisite for making an order is not that the measure will reduce transmission. Rather, the measures must "contribute or [be] likely to contribute to preventing the risk" of outbreak or spread. They are measures that only have to "contribute" to preventing a risk. These provisions contemplate a risk minimisation approach. That is particularly clear when the text of the enactment is interpreted in light of its purpose.

[69] It is perhaps surprising that the measures in the Order directed to the border workers refer only to vaccination. I am satisfied by the evidence on the point that vaccination is likely to materially contribute to minimising the risk of outbreak or spread. However, as some of the scientific papers I have considered point out, including those referred to by Dr Febery and Dr Thornley, reliance should not be placed on vaccination alone. Other measures are important. One might have expected the Order to refer not only to vaccination, but also to other requirements such as physical distancing, PPE and regular testing. The last matter might be of importance given the greater potential for asymptomatic transmission of the Delta variant, a matter expressly referred to in the purpose provision of the Act.[45]

[70] It may have been assumed by the respondents that these other measures will have been required as a matter of good practice by the employer, and that vaccination was the only measure mandated by the Order because of a greater perceived uncertainty about the authority of employers to require that employees be vaccinated. But their omission is still notable. In any event, however, the fact that other measures contributing to the prevention of the outbreak or spread of COVID-19 were not specified in the Order does not make the Order inconsistent with its empowering provision.

[71] For these two reasons I accept that the statutory prerequisite existed for making the Order.

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[45] COVID-19 Public Health Response Act, s 4(a).

Other grounds of challenge

[72] Finally I address the other matters advanced by the applicants in support of their argument that the Order was ultra vires.

[73] First, the applicants argued that the Minister had no power to exercise delegated powers in conflict with other statutory, contractual or international law obligations, including obligations under employment law. Ms Grey referred to the provisions in the Health Act preventing compulsory treatment[46] and to the concurrent obligations in employment contracts seen in light of the protection for agreements in the Employment Relations Act 2000 and Article 23(1) of the Universal Declaration of Human Rights.[47]

[74] The answer to these submissions is found in the provisions of the Act. Section 13(1)(a) provides that a COVID-19 order may not be held invalid just because it authorises an act or omission that is inconsistent with the Health Act. More generally, orders made under the Act can be taken to prevail over the provisions of the Health Act because it addresses particular measures relating to COVID-19. Section 12 provides that an order may be made to cover various potential situations specified in that section — for example generally to all people in New Zealand, or to a specific class of people.[48] There is nothing in the legislation that suggests that orders made under it are precluded from impacting, or be inconsistent with, the normal rights and obligations obtaining between employers and employees. It is to the opposite effect.

[75] Finally Ms Grey argued that the Order improperly purported to delegate statutory duties to employers or employees. She argued that this conflicted with the general principle that a delegated power could not be sub-delegated. She referred particularly to the duties of employers under cl 8 of the Order, and the obligation of employees under cl 7 not to carry out work unless they have been vaccinated. The answer to this argument is, again, in the wording of the empowering provision. This expressly allows orders made under it to require persons to undertake specified actions

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46 Health Act 1956, ss 92I(5) and 92ZV(2).

47 Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

48 COVID-19 Public Health Response Act, s 12(1)(b)(i).

or comply with specified measures associated with activities, provided that they meet the statutory standards that I have already addressed. This naturally contemplates activities occurring in the course of employment. The specified measures or actions can legitimately be specified as to be taken by employers and/or employees. In fact, the words "require to take any specified actions, or comply with any specified measures" in s 11(1)(a) imply that those very "specified actions" will have to be taken by the persons subject to the order, namely employers and employees. I do not accept this involves any impermissible sub-delegation.

Conclusion on ultra vires

[76] Accordingly, for the reasons I have outlined above, I do not accept the applicants' arguments that the Order is ultra vires.

[77] I note, however, that this is not a self-evident conclusion. It is perhaps of some surprise that such an important aspect of the response to the risk of COVID-19 has been implemented through a section that makes no express reference at all to vaccination. A very substantial measure is being implemented through a generally expressed empowering provision. Because the provision does not expressly address vaccination or the issues arising from it, a degree of uncertainty does arise from its use as the basis of such an order. The respondents' evidence shows that at an earlier stage a decision had been made to legislate in this area. That idea appears to have fallen away for reasons that are not clear. It may be that significant measures of this kind are better suited to legislation that squarely addresses the issues that arise from the measures. None of this means that the Order is invalid, but neither should my conclusion be interpreted as clearing a path for more extensive use of this power for other circumstances.

Is the Order consistent with the Bill of Rights?

[78] I next address what I apprehend to be the key question in this case: whether the Order is unlawful because it introduces measures that are not a demonstrably justified limit on the freedom to refuse medical treatment.

[79] As explained earlier, this is a question that the Court must itself ask. It is not a matter of reviewing a decision made under statutory powers, here by the Minister. It is whether the measure itself is compliant with the Bill of Rights. If it is not, it is unlawful.

The Court's approach

[80] There are important preliminary questions directing the approach that the Court should apply to this question. Mr Powell accepted that the question whether the measure was demonstrably justified was a question of law for the Court to decide. But he argued that there was a degree of latitude, or deference, informing this assessment. He referred to the observations of Lord Hoffman in *R (ProLife Alliance) v British Broadcasting Corporation* where he said:[49]

> My Lords, although the word "deference" is now very popular in describing the relationship between the judicial and the other branches of government, I do not think that its overtones of servility, or perhaps gracious concession, are appropriate to describe what is happening. In a society based upon the rule of law and the separation of powers, it is necessary to decide which branch of government has in any particular instance the decision-making power and what the legal limits of that power are. That is a question of law and must therefore be decided by the courts.
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> This means that the courts themselves often have to decide the limits of their own decision-making power. That is inevitable. But it does not mean that their allocation of decision-making power to the other branches of government is a matter of courtesy or deference. The principles upon which decision-making powers are allocated are principles of law. The courts are the independent branch of government and the legislature and executive are, directly and indirectly respectively, the elected branches of government. Independence makes the courts more suited to deciding some kinds of questions and being elected makes the legislature or executive more suited to deciding others. The allocation of these decision-making responsibilities is based upon recognised principles. The principle that the independence of the courts is necessary for a proper decision of disputed legal rights or claims of violation of human rights is a legal principle. It is reflected in Art. 6 of the Convention. On the other hand, the principle that majority approval is necessary for a proper decision on policy or allocation of resources is also a legal principle. Likewise, when a court decides that a decision is within the proper competence of the legislature or executive, it is not showing deference. It is deciding the law.

[81] Mr Powell argued that a need for what might be described as a margin for appreciation, or the need for deference, arose in the present case. He referred to the

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[49] *R (ProLife Alliance) v British Broadcasting Corporation* [2002] UKHL 23, [2004] 1 AC 185 at [75]–[76].

recognition of such concepts by Ellis J in the interim relief decision with respect to the challenge to the roll out of the vaccine.[50]

[82] I do not accept that that is so in the circumstances of the present challenge. As Lord Hoffman observed a question of law is a question for the Court. Here there is no question of deference. The Court is not reviewing the decision of the Minister, it is reviewing the legality of the measure that was imposed by his decision. So it is not a question of deferring to the views of the Executive. The only other candidate for deference would be the Crown's experts who have provided evidence to the Court. But it is not appropriate to show deference to one side's experts as opposed to the other. So I do not find the concept of deference to be of assistance.

[83] Mr Powell also referred to the potential for questions of policy, discretion and political judgment to be involved in cases of this kind, referring to the decision of the House of Lords in *R (SB) v Governors of Denbigh High School*.[51] There the House of Lords concluded that the legislation in issue legitimately gave a discretion to schools to make decisions on the particular types of dress that Muslim students should wear.[52] I accept that such a discretion can be given in a way that does not infringe rights. I also accept that here there is room for different policies in the COVID-19 response. The Government's decision to "go hard, go early" and pursue an elimination strategy involve such policies and decision-making made by duly elected representatives. But that decision-making is only the background to the more confined and ultimately legal question that is now in issue. That legal question is whether the measure requiring aviation security workers interacting with international travellers to be vaccinated is demonstrably justified. This is a legal question that is the outcome of Government policy. The policy itself is not challenged. Only the particular measure is.

[84] I do accept, however, that there is a limit on the Court's ability to address the issues in an evidential sense. At the heart of the argument are questions of science upon which the views of experts have been provided on the effect of the vaccine to inhibit the transmissibility of COVID-19 and particularly the Delta variant. Just as in

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50 *Nga Kaitiaki Tuku Iho Medical Action Society Inc v Minister of Health and Ors*, above n 19, at [73]. That case did involve a challenge to the decisions made by an expert body.

51 *R (SB) v Governors of Denbigh High School* [2006] UKHL 15, [2007] 1 AC 100.

52 See, for example, at [63]–[64] as per Lord Hoffman.

New Health, there are limits on the Court's ability to reach determinations on such questions of science when they are disputed.[53] In that context I note that the Supreme Court of New South Wales recently addressed COVID-19 orders made under legislation prohibiting certain workers from leaving certain areas in which they resided, and prohibiting others from working in particular occupations unless they had been vaccinated.[54] Faced with a contest of expert evidence the Court in that case also commented on the limitation on its ability to conclusively resolve the debates arising from that evidence.[55]

[85] This must be particularly so in the context of a judicial review proceeding. The Courts are accustomed to resolving complex questions of expert evidence. But in a judicial review proceeding with evidence only by way of affidavit there are forensic limits on what the Court can properly determine, particularly when the evidence is only filed at the very end of the proceeding.

[86] When it is alleged that statutory powers have been exercised in a manner that limits fundamental rights in a way that is not demonstrably justified, and it is established (or, as here, admitted) that the right is in fact limited, the burden falls on the Crown to put forward evidence that the limitation is demonstrably justified. But if the applicant then wishes to establish that what that Crown's evidence establishes is factually wrong, it still has the burden to persuade the Court of this.

[87] In the present case the Crown has filed relevant evidence from Dr Bloomfield, Dr Town and from Mr James (the Group Manager of Medsafe). The evidence of Dr Bloomfield and Dr Town, and the underlying information to which they have referred, forms the evidential basis for the Crown's argument that the measure is demonstrably justified. The applicants initially filed no expert evidence of this kind. Dr Febery put relevant publications and articles before the Court, particularly in her evidence in reply. I accept that that material is to be properly considered by the Court in its assessment of whether the measures are demonstrably justified, but it is not expert evidence of the kind filed by the respondents.

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53 *New Health New Zealand Inc v South Taranaki District Council*, above n 24, at [121]–[122].

54 *Henry v Hazzard* [2021] NSWSC 1320.

55 At [144].

[88] After I gave the respondents the opportunity to respond to Dr Febery's reply affidavit, the applicants filed expert evidence from an epidemiologist, Dr Thornley. I have been prepared to take that into account even though it has been filed after the hearing without leave, and after the filing of all other evidence on the key issues. But the applicants still have the burden to show that the respondents' evidence justifying the measure is wrong, and because they have only filed this evidence at the very end I proceed cautiously. The approach I adopt is to consider the expert views of Dr Bloomfield and Dr Town, and the underlying material to which they refer, testing or challenging their views against the opinions put forward by Dr Thornley and materials provided by Dr Febery before ultimately reaching a conclusion.

[89] I address the legal question of whether the measures were demonstrably justified against that evidential background.

The justification for vaccination

[90] In assessing whether a measure is demonstrably justified the usual approach is to adopt the framework that was set out by the Supreme Court of Canada in *R v Oakes*[56] subsequently adopted in New Zealand by the Supreme Court in *R v Hansen* and then applied in other cases.[57] This involves answering the following questions:

(a) does the limiting measure serve a purpose sufficiently important to justify curtailment of the right or freedom?

(b) do the means chosen to achieve that objective pass a proportionality test, that is:

(i) is the limiting measure rationally connected with its purpose?

(ii) does the limiting measure impair the right or freedom no more than was reasonably necessary for sufficient achievement of this purpose?

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56 *R v Oakes* [1986] 1 SCR 103.

57 *R v Hansen*, above n 32, at [103]–[104]

(iii) is the limit in due proportion to the importance of the objective?

[91] That is only a framework however, and in the present case the critical issues are really evidential ones. I note that O'Regan and Ellen France JJ did not apply this framework in *New Health*, potentially for similar reasons. In the present circumstances I intend to address the following matters to determine whether the measures in the Order are demonstrably justified:

(a) what is the nature of the harm from COVID-19 that the measures are seeking to address?

(b) does vaccination materially address that harm in a justifiable and proportionate way?

(c) do the other issues raised by the applicants affect whether the measure is justified?

The nature of the harm

[92] The first step is to assess the nature of the harm that the measure is seeking to address.

[93] The applicants argue that the harm from COVID-19 has been exaggerated. But I have little hesitation in accepting the respondents' evidence on this issue. Dr Town explained that COVID-19 causes significant harm to the community. He gave evidence that as at 21 September 2021 the WHO had confirmed that there had been 228,807,631 confirmed cases of COVID-19, including 4,697,099 deaths, reported.[58] He indicates that in New Zealand, even assuming that a figure used by Dr Febery was accurate, the virus would cause around 7,500 deaths if left unchecked. He also pointed out that New Zealand's most vulnerable communities would be worse off in this scenario.

[58] I note that as of the date of this judgment, the World Health Organisation records over 246 million confirmed cases of COVID-19 worldwide and over five million deaths.

[94] In addition there is the impact on the public health system referred to by Dr Bloomfield. He gave evidence that modelling showed that unchecked community transmission would quickly overwhelm the health system. There would then be major consequences for those who need access to that system for conditions unrelated to COVID-19. Mr James gave evidence that the pandemic had caused an unprecedented public health crisis around the world including New Zealand with significant health, social and economic impacts. I also take judicial notice of the measures that have been taken all around the world to seek to address the significant impacts of COVID-19, including the highly restrictive measures taken in attempts to control its spread.

[95] The key point is that there are very profound impacts of the virus not only on the health of New Zealanders but also in the form of severe social and economic disruption.

[96] At the time the Order was made New Zealand had managed to completely eliminate the presence of the virus in the community. At the time of issuing this judgment, there has been a further outbreak in Auckland that has been spreading notwithstanding the lockdown measures imposed. Both steps — preventing an outbreak, and preventing spread once an outbreak has arisen — are directed to avoiding the very significant harm that the virus would cause if left unchecked.

[97] In their submissions the applicants contended that the adverse impacts of COVID-19 have been overstated. Ms Grey argued that positive cases from COVID-19 arise from positive tests rather than from significant symptoms, that the death rate and transmissibility of Delta was similar to influenza, that reported COVID-19 deaths were mainly deaths *with* COVID-19 not *from* COVID-19, that early treatment protocols had been shown to be highly effective at keeping people out of hospital, and that alternative therapeutic measures were effective at treating it. I did not find persuasive support for these propositions in the applicants' evidence, and they were directly contradicted by the expert evidence filed by the respondents. To demonstrate to the Court that New Zealand's public health response has been based on a fundamental misunderstanding of the nature of COVID-19, and that the Director-General of Health, the Ministry of Health Chief Science Advisor, and Medsafe's

Group Leader, as well as the other experts who support their views, have all got this wrong would require the applicants to put forward compelling evidence.

[98] I did not understand Dr Thornley's evidence to dispute the respondents' evidence on the harm arising from COVID-19, although I note that he referred to a basic principle of virology that as viruses mutate they tend to become more transmissible but less severe. I understood his evidence to be more directed to the efficacy of vaccination, and the possible harm posed by vaccination. It is apparent that Dr Febery's evidence is more relevant to contesting the evidence on the seriousness of COVID-19, but I respectfully did not find it persuasive in responding to the evidence of the respondents.

[99] I accordingly accept the respondents' evidence on this issue, and accordingly accept that the existence and spread of COVID-19 within the New Zealand community would have profoundly adverse health implications for the country as a whole, profound adverse impacts for those who are killed or are made severely ill from it, and profound adverse effects from a social or economic perspective.

Does vaccination suppress transmission?

[100] The next step is to address whether mandating vaccination for the relevant border workers materially addresses these matters.

[101] The evidence establishes that the vaccine is highly effective in preventing symptomatic infection. Dr Town's evidence is that the studies overall show that even against the Delta variant, the vaccine offered effective protection against symptomatic infection of around 88 per cent. The formal scientific advice referred to by Dr Town also referred to studies from the United Kingdom noting the effectiveness of the Pfizer vaccine against confirmed infection at 79 per cent, and symptomatic protection at 88 per cent (compared with the Alpha variant at 92 and 93 per cent respectively). The formal advice reported that vaccines offer substantial protection against hospitalisation and death from COVID-19 variants, including the Delta variant. It reported that the data suggests that the vaccine was 96 per cent effective at preventing hospitalisation.

[102] But the protection that the vaccine provides at an individual level does not by itself provide justification for requiring compulsory vaccination of border workers. In the fluoride debate addressed in *New Health,* the public benefit was derived from the benefit to the community overall in addressing bad oral health. Here, the workers at the border are not being required to be vaccinated because of the benefit of the health system that may follow from avoiding the demands on the system from their own COVID-19 infection. The measure is only justified if it provides a wider public benefit. And in the end that comes down to a single issue — whether the vaccine contributes to suppressing the transmission of the Delta variant of COVID-19.

[103] Dr Bloomfield explains that in February and March 2021 the Ministry did not recommend the mandatory vaccination of border workers. He said:

> … We were advised that vaccination constitutes medical treatment and therefore engages the right of every person to refuse it if they choose. Requiring vaccination to perform specific high-risk roles at the border would be inconsistent with that right unless it can be demonstrably justified. A demonstrable justification could be impeding community transmission of the virus. But we did not yet have conclusive evidence on the effectiveness of the Pfizer vaccine at preventing or reducing transmission to be confident of the public health value of the vaccination beyond the individual level. We noted though that might change as more evidence becomes available.

[104] He then explains that by the end of April the Minister was considering taking stronger measures, including the measure in issue in this case. Dr Bloomfield then explains that whilst the scientific evidence was still evolving at that time, the indicators were present by then that the vaccine did have an appreciable impact on transmission. He said:

> From a public health perspective, there is generally a reluctance to provide assertive advice without being able to reference peer-reviewed studies (and these studies can take time to become available). That said, at the time of the original Vaccinations Order, I was confident that the vaccine was reducing transmission. We could see signs in the United Kingdom and other places where the vaccine rollout was further advanced that daily cases and hospitalisations were trending down. We knew that the vaccine was effective in reducing symptoms, and symptoms (in particular coughing and sneezing) were, at that time, one of the key players in transmission as particles would be expelled in a greater amount and at a greater velocity increasing the chances of affecting another person. We also knew that the vaccine could reduce viral load four fold, which is another key driver in transmission.

> On that basis, I advised there is a public health rationale for requiring specified high-risk roles only be undertaken by vaccinated individuals in response to the COVID-19 pandemic.

[105] Similar evidence was given by Dr Town. He says that in May 2021 he was confident in advising Dr Bloomfield that the vaccine had a significant effect on community transmission, but indicates that there were limited data on the effectiveness of the vaccine against the Delta variant, including its the effect on transmission. The formal science advice provided to the Minister when the Order was made stated that the studies suggested that people who became infected with Delta were less likely to be infectious if they had been vaccinated before contracting the virus, but that additional data to confirm these views was needed.

[106] This evidence was disputed by Dr Thornley, who said that Dr Town's evidence failed to "recognise or address the many studies which now confirm that the Pfizer vaccine is ineffective at stopping transmission of the Delta variant". I have looked carefully at Dr Thornley's evidence to understand the basis for that conclusion. One of the key studies he referred to had been addressed by both Dr Febery and Dr Town. It is from the University of Oxford involving significant community surveillance. But that study does not seem to me to stand for Dr Thornley's conclusion. For instance, in addressing peak viral load, an apparently important factor in transmissibility, the authors stated:[59]

> … Peak viral load therefore now appears similar in infected vaccinated and unvaccinated individuals, with potential implications for onward transmission risk, given the strong association between peak Ct and infectivity. However the degree to which this might translate into new infections is unclear; a greater percentage of virus may be non-viable in those vaccinated, and/or their viral loads may also decline faster as suggested by a recent study of patients hospitalised with [Delta] … leading to shorter periods 'at risk' for onwards transmission. Nevertheless, there may be implications for any policies that assume a low risk of onward transmission from vaccinated individuals (for example, relating to self-isolation and travel) despite vaccines both still protecting against infection, thereby still reducing transmission overall. This may be particularly important when vaccinated individuals are not aware of their infection status or perceive that their risk of transmission is low. Notably, individuals infected after second vaccination appear to gain an antibody boost, and higher prior antibody levels were independently associated with lower viral burden.

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59 K.B Pouwels and others "Effect of Delta variant on viral burden and vaccine effectiveness against new SARS-CoV-2 infections in the UK" (2021) Nat Med at 8 (footnotes omitted).

[107] I do not take evidence from this study as confirming that the vaccine is "ineffective at stopping transmission" as suggested by Dr Thornley. Moreover his evidence then went on to say, in relation to the various studies that have been presented in evidence, that "there is clearly a mix of epidemiological evidence, some suggesting some effectiveness of the COVID-19 vaccine [in reducing transmission], some suggesting none". That is very different from saying that the evidence now confirms that the vaccine is ineffective at stopping the transmission of the virus.

[108] In Ms Grey's supplementary submissions she submitted that Dr Town's evidence relating to two studies that suggest vaccinated and unvaccinated individuals infected with COVID-19 have similar viral loads in the first six to seven days of infection was "extremely significant". That was because she argued that after six or seven days the workers in the position of the applicants would already have tested positive with their regular PCR testing and would be self-isolating. That is not a point that is focused on by the expert evidence relied upon by the applicants, and it seems to me that the submission is based on underlying assumptions on the definitiveness of the conclusions in these studies that may not be justified. The passage that I quoted from the Oxford study suggests that the transmission issues are more complex.

[109] Overall the conclusion that is properly drawn from all the evidence is that the vaccine is effective at reducing the transmission of the earlier variants of the virus, and that it is also effective at reducing symptomatic infection and the detrimental effects of the Delta variant. For those two related reasons it is likely to be effective at reducing the transmission of the Delta variant. But this has not yet been proved by clinical studies. More generally the evidence establishes that vaccination provides clear benefits in responding to COVID-19. A person who is vaccinated is far less likely to be symptomatically infected with the Delta variant, and far less likely to be seriously ill or die. That does not necessarily mean that vaccination will suppress transmission. A vaccinated person may be less likely to be symptomatically infected, but there may still be asymptomatic infection. An asymptomatic person may be less likely to cough and sneeze in a way that may spread the virus, but with Delta it may not be necessary to have coughing and sneezing for there to be transmission. Asymptomatic spreading by vaccinated people may explain some of the evidence relied on by Dr Thornley and Dr Febery suggesting that high vaccination rates in other countries have not prevented

continuing high case numbers. But such possibilities do not mean that vaccination does not inhibit transmission. It just means there are uncertainties.

[110] There is no need for proof on a scientific basis. I am satisfied that it is likely that vaccination contributes to preventing the risk of transmission. We are dealing with the position of border workers interacting with international travellers who may be carrying the virus. It can be presumed that vaccination is used along with other measures such as regular testing, physical distancing, and PPE as well as measures directed at the international travellers themselves (such as pre-departure testing). A risk minimisation approach is appropriate. None of the measures by themselves — physical distancing, PPE, regular testing and vaccination — guarantee that the virus will not get into the community. Subsequent events have shown that. But there is a strong public interest in doing everything that can reasonably be done to minimise the risk of such an outbreak, or its spread. A precautionary approach is justified. Vaccination is likely to contribute to preventing the risk of an outbreak or spread, adopting the words of s 11(1)(a). That contribution to addressing the risk is sufficient in itself for the measure to be demonstrably justified, even if the evidence on the effect on transmissibility is uncertain.

[111] I have gone carefully through the publications and scientific papers referred to in Dr Febery's affidavit, and then the evidence of Dr Thornley. This evidence does not satisfy me that vaccination has no impact on transmission of the Delta variant. At best they show that more work is required to get a better understanding of the transmissibility issues. The evidence provided by the applicants is not sufficient to show that the evidence presented by the respondents is wrong. A risk minimisation approach is appropriate in the face of scientific ambiguity. As the Newfoundland and Labrador Supreme Court held when considering the evidence associated with a challenge to COVID-19 measures.[60]

> … In the context of such a public health emergency, with emergent and rapidly evolving developments, the time for seeking out and analyzing evidence shrinks. Where the goal is to avert serious injury or death, the margin for error may be narrow. In such a circumstances, the response does not admit of surgical precision. Rather, in public health decision making the

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60 *Taylor v Newfoundland and Labrador* [2020] NLSC 125 at [411].

> "precautionary principle" supports the case for action before confirmatory evidence is available.

[112] This is consistent with the views of McLachlin J in *RJR–MacDonald Inc v Canada* that "proof to the standard required by science is not required" but rather "the application of common sense to what is known, even though what is known may be deficient from a scientific point of view".[61] On that basis I accept that the mandatory vaccination of border workers having contact with potentially infected persons from overseas is a legitimate part of the measures put in place to reduce the risks of an outbreak or spread of the virus. On that basis the measure is demonstrably justified.

Other factors raised by the applicants

[113] I next address the other factors that were raised by the applicants.

[114] I have already addressed their claims that COVID-19 is not as serious as claimed,[62] and that the vaccine's efficacy is exaggerated.[63] On the evidence I do not accept the applicants' propositions, and accept the evidence filed by the respondents addressing those matters.

[115] Another factor raised by the applicants is that the vaccine is not safe and "may cause death or serious adverse effects". Ms Grey took me through Pfizer's own disclosures concerning potential adverse effects which include references to anaphylaxis, myocarditis, pericarditis and stress related responses. In addition, Dr Febery provided evidence to the effect that adverse side affects were not being properly reported based on her own experience with her patients, and additional research she had conducted into events around New Zealand. Dr Febery explained that there was only passive recording of adverse events, rather than proactive attempts to seek out and find such adverse effects, and that this meant that such events were being under reported. It was also argued that recipients of the vaccine should be informed that there have been a number of deaths from the vaccine, and that the extent of this was not fully recorded.

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61 *RJR–MacDonald Inc v Canada* [1995] 3 SCR 199 at [137]; see also *New Health New Zealand Inc v South Taranaki District Council*, above n 24, at [118] and [122].

62 At [93]–[97] above.

63 At [101] above.

[116] Dr Town responded to this evidence indicating that Dr Febery's evidence in relation to under recording of deaths was false. He explained the adverse event reporting system, and that it was subject to enhanced surveillance. He then said:

> This is not to say that there are no side effects from the vaccine. Common side-effects (reported in every 1 in 10 to 1 in 100 people in clinical trials) include: pain or swelling at the injection site; feeling tired or fatigued; headache; muscle aches; chills; joint pain; fever; redness at the injection site; and nausea. Uncommon side-effects (reported in every 1 in 100 to 1 in 1,000 people in clinical trials) include: enlarged lymph nodes, feeling unwell, pain in limb, insomnia and itching at injection site. Rare side effects (affecting every 1 in 1,000 to 1 in 10,000 people) including temporary one-sided facial drooping and temporary inflammation of the heart muscle (myocarditis). These side effects are published on the Ministry of Health's website.[64]

[117] This question was also then addressed by Dr Thornley who said that there was increasing evidence of overall harm caused by widespread use of the Pfizer vaccine, and that recent rapid increases in reports of adverse effects should be a cause for concern.

[118] In the absence of cross examination where the different views of Dr Thornley and Dr Town could be tested in a way that allowed the Court to form clearer views of the evidence, I am not satisfied that Dr Town's evidence is wrong.

[119] Moreover, even if it were true that there was some underreporting of adverse events from the virus it would still not alter the essential balance of considerations that are key to determining whether the measures here are demonstrably justified. I am satisfied that the benefits of the vaccine are demonstrably high, with there being a need to take a risk minimisation approach to stop an outbreak or spread of the virus at the potential entry point of the virus into New Zealand. Employees in the position of the applicants are not being literally forced to vaccinate. They have lost their job as a consequence of choosing not to, but they still retain ultimate personal autonomy. They are not obliged to take the risks referred to in their argument.

[120] I do accept the applicants' evidence, referred to by both Dr Febery and Dr Thornley, that it is significant that the efficacy of the vaccine may be relatively

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64 "COVID-19: Vaccine side effects and reactions" (3 November 2021) Ministry of Health <www.health.govt.nz>.

short lived. That is apparent from the materials referred to in the evidence, including the respondents' evidence. As Dr Thornley says, the emergence of the need for booster shots effectively confirms this. I am not in a position to reach any conclusions on the time periods involved in this waning effect. But I do not see how that is truly relevant to the issue before the Court, as this may simply mean that border workers will need to receive a booster shot.

[121] The final factor raised by the applicants, emphasised by Ms Grey in reply, was the desirability of taking a more individualised approach to a vaccine mandate, and the associated desirability of providing exceptions for those who could not, for medical or ethical reasons be expected to be vaccinated. The evidence establishes that the Minister considered whether to allow exceptions to the vaccination requirement, and that exceptions were only permitted for those handling items where the risks of transmission were much lower. The Minister decided not to create such exemptions for persons in the position of the applicants here. Ms Grey contended that that was unjustified, and accordingly that the Court should conclude there is an unjustified limitation because of the lack of such exceptions.

[122] For two related reasons I do not accept this argument. First, I accept that it would be difficult to identify the dividing points for such exceptions, as was said in advice of the Ministry of Health at the time the Order was considered. It may be easier in relation to someone with a medical condition that meant that vaccination was not appropriate for them, but the position would be much harder if exceptions were required for wider circumstances such as religious or ethical beliefs.

[123] In any event if such persons were exempted they would still potentially represent an increased risk of the entry or spread of the COVID-19 risk from border workers. The risk minimisation approach is still demonstrably justified. The individual may have a more objectively compelling reason not to be vaccinated, but the demonstrable justification depends on the mandate being appropriate even in the face of such compelling reasons. Questions such as redeployment will become relevant, and an employer may have a greater duty to find alternatives when someone has an objectively justifiable reason not to be vaccinated. But in terms of the

justification for the vaccine mandate for these employees I do not consider this a significant consideration.

Conclusion on legitimacy

[124] Given the above findings I return to the ultimate question — whether the limit upon the s 11 right prescribed by law is demonstrably justified in a free and democratic society. I apply the steps from *R v Oakes* adopted in New Zealand in *R v Hansen* to do so. My conclusions are that:

(a) The compulsory vaccination of these workers serves a purpose sufficiently important to justify curtailment of the right.

(b) The means chosen to achieve the objective of minimising the risk of an outbreak of, or spread of COVID-19 in New Zealand is proportionate as:

(i) the measure is rationally connected with its purpose;

(ii) the measure impairs the right of freedom no more than is reasonably necessary for the sufficient achievement of that purpose; and

(iii) the limitation is in due proportion to the importance of the objective.

[125] Apart from the factors I have already addressed it is also important to note that those in the position of the applicants are not actually compelled to be treated. They retain the option to refuse vaccination. The implication is that, if they are unable to be redeployed by their employer, their employment may be terminated. That has happened for the applicants. But what they have lost is their job, rather than their right to refuse to be vaccinated. That is relevant to assessing the proportionality of the measures imposed here. The Act is not being used to literally compel vaccination for anybody.

[126] I accept that the evidence that the vaccine materially reduces transmission of the Delta variant is uncertain. This has not been proved in a scientific sense. I conclude that it does contribute to reducing transmissibility, and that it accordingly contributes to minimising the risk of the outbreak or spread of COVID-19. But it is an open question that may be more readily demonstrated as further evidence comes to light. On the scientific evidence as it currently stands the measure can be justified on a risk minimisation basis given the implications of an outbreak, or the spread of COVID-19.

[127] I accordingly conclude that the measure is demonstrably justified, and the Order is accordingly not invalid for being inconsistent with the Bill of Rights.

[128] There is a last point of significance. This case concerns the measure that was introduced when New Zealand had eradicated the virus after the first outbreak, and was seeking to prevent a further outbreak (or delay a further outbreak until a greater proportion of the population is vaccinated, means of treating and managing the virus are better known, and the health system is better organised to address such an outbreak). Since that time it is a matter of judicial notice that an outbreak has occurred in Auckland, and that COVID-19 is spreading. It does not appear that this outbreak can be eliminated, reflecting the greater transmissibility of the Delta variant. Whether the challenged measure would remain demonstrably justified on the basis that it contributes to addressing the spread of the virus in circumstances when the virus is endemic in at least parts of New Zealand is an open question. This question is not before me. I note that under s 14(5) of the Act the Minister and Director-General are obliged to keep their COVID-19 orders under review.

[129] I also note that given the uncertainties about the effect of the vaccine in reducing transmission it remains surprising that vaccination measures of this kind have not been addressed in primary legislation. There are limits on the legitimate use of generally expressed powers for measures that have very significant impacts, including impacts that involve limitation of fundamental rights, in order to implement key national policies.

The applicants' challenges to the Minister's decision

[130] As indicated the applicants' second and third causes of action challenge the Minister's decision to promulgate the Order under the Act on what can be regarded as conventional judicial review grounds. Given my conclusions above I can address these matters more succinctly.

[131] Ms Grey relied on the requirements set out in s 9(1)(ba) that the Minister himself must have been satisfied that the Order did not limit, or was not an unjustified limit on, the rights in the Bill of Rights. In addressing that question she argued that he had asked the wrong questions, made assumptions that were unsupported by the evidence and as a result reached a conclusion that no reasonable Minister could reach.

[132] She relied on the High Court's decision in *Christiansen v The Director-General of Health* where Walker J held:[65]

> [67] I have also considered the question of the appropriate deference to the expertise of the decision makers in a time of unprecedented public crisis. No matter how necessary or demonstrably justified the COVID-19 response, decisions must have a clear and certain basis. They must be proportionate to the justified objective of protecting New Zealand bearing in mind the fundamental civil rights at issue – freedom of movement and of assembly in accordance with the New Zealand Bill of Rights Act 1990.

[133] Ms Grey also referred to the advice of the Attorney-General when the Act was passed, and the lack of any reference to compulsory vaccination, or on limits on the right to be free from medical treatment, in that advice.

[134] She then contended the Minister had failed to address the real risks involved, including that:

(a) COVID-19 had a death and transmission rate similar to influenza;

(b) the Pfizer vaccine had only received provisional consent;

(c) the vaccine may cause an array of adverse effects, and even death;

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[65] *Christiansen v The Director-General of Health* [2020] NZHC 887.

(d) it is contraindicated for some medical conditions and had not been assessed for others;

(e) it did not prevent infection or infection of COVID-19;

(f) there is no reliable evidence that it prevents transmission or infection of the Delta strain;

(g) any benefits on severity of the disease were short-lived and that booster shots are typically required; and

(h) other well established treatments are effective at reducing symptoms and treating COVID-19.

[135] In oral submissions she emphasised that there had not been a comprehensive risk benefit analysis, and that the Minister's consideration was not sufficiently detailed or comprehensive to justify such a significant measure. Rather, the Minister had conducted only a narrow analysis influenced with a single-minded approach. He had also not considered the variability on the effect of the measure on individuals, adopting a one-size fits all analysis. She contended that there had been a failure to consider mandatory relevant considerations, a failure to ask the sort of questions that were necessary to justify such a measure, and that his decision was ultimately irrational or unreasonable as a consequence.

[136] I do not accept the applicants' arguments.

[137] An important feature of Ms Grey's argument centred on how the Bill of Rights should have influenced the Minister's decision-making. Given that the measure is limiting a right under the Bill of Rights, she argued that as a matter of interpretation the Court should accept that there were mandatory relevant considerations that needed to be addressed, and that the Order was unreasonable. But as I have indicated the Court itself must be satisfied that the measure is a demonstrably justified limit on the s 11 right. That is an objective requirement of the law. Parliament has also required that the Minister be satisfied of that matter, and the requirement for the Minister's

satisfaction on that question provides an additional layer of protection. But the Minister's opinions are not a substitute for the objective limits on the powers required as a matter of law.

[138] For the reasons outlined above I have concluded that the Order is not inconsistent with the Bill of Rights. I have also addressed, and not accepted, many of the arguments relevant to the applicants' allegations relevant to these two claims. Against that background it is not as clear that there are mandatory relevant considerations of the kind relied upon arising as a matter of implication. The Bill of Rights controls the power more directly. So the limitations referred to by Walker J in *Christiansen* arise directly, rather than indirectly.

[139] In any event I do not accept the applicants' arguments on the evidence. I am satisfied that the Minister asked himself the right questions, taking into account the right considerations, and focusing on the key question of whether vaccination materially contributed to reducing the risk of transmission. I do not accept the allegations that the Minister failed to take into account relevant matters.

[140] I also do not accept Ms Grey's submission that the Minister failed to remember that the vaccine had only provisional, and not final approval under the Medicines Act. That is inconceivable — the status of the approval was well-known, had been subject to Court challenge, and was the subject of a Parliamentary amendment. The suggestion that the COVID-19 Response Minister was not aware of that when he made his decision to implement the Order has no foundation.

[141] The other contentions advanced by Ms Grey that I referred to in paragraph [134] above are not established as a matter of fact. They are factual assertions about the vaccine which are not established by the evidence that has been filed by the applicants, and are essentially disproved by the respondents' evidence. I also reject the contention that the measures in the Order are unreasonable or irrational. Indeed I have concluded that they are demonstrably justified.

[142] For these reasons I dismiss the applicants' second and third causes of action.

Conclusion

[143] I have carefully considered the applicants' challenge. That has included a consideration of Dr Febery's evidence, and particularly the publications and scientific papers that she put forward in her reply affidavit directed to the efficacy of the vaccine, and its impact on transmission. I have also considered Dr Thornley's evidence. I do not accept the applicants' challenge that the vaccine is experimental, unproven, unsafe and that it has little effect on transmission. I am satisfied that the vaccine is safe and effective, is significantly beneficial in preventing symptomatic infection of COVID-19 including the Delta variant, and that it significantly reduces serious illness, hospitalisation and death. I also accept that it is likely to materially assist in preventing the risk of an outbreak or the spread of COVID-19 originating from border workers having contact with potentially infected persons from overseas. More generally for the reasons I have explained in detail above I accept that the measure contained in the Order is demonstrably justified in a free and democratic society. I accept that the Order is within the empowering provision in the Act, and that it has not been implemented by an irrational decision, or one that involved a failure to consider relevant considerations.

[144] The applicants' challenge is accordingly dismissed.

[145] On the question of costs, should the respondents seek costs they should file and serve a memorandum (no more than 10 pages plus a schedule) within 10 working days which can be responded to by the applicants (no more than 10 pages plus a schedule) within 10 working days. Amongst the matters to be considered will be whether r 14.7(e) of the High Court Rules 2016 applies such that there should be no award of costs against the applicants, or a reduced costs award. This is on the basis that their fundamental rights under s 11 were limited, they have lost their employment as a consequence, and that there should be no impediment to their right to have access to the Court to challenge the potential legitimacy of the orders having those impacts in the circumstances of this case.

Cooke J