IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

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

CIV-2021-485-595
[2022] NZHC 716

UNDER	the Judicial Review Procedure Act 2016 and the Declaratory Judgments Act 1908
IN THE MATTER	of the making and amendment of the COVID-19 Public Health Response (Vaccinations) Order 2021 under s 11 of the COVID-19 Public Health Response Act
BETWEEN	NZDSOS INC First Applicant
	NZTSOS INC Second Applicant
AND	MINISTER FOR COVID-19 RESPONSE First Respondent
	DIRECTOR-GENERAL OF HEALTH Second Respondent
	ATTORNEY-GENERAL Third Respondent

Hearing: 3, 4 and 7 March 2022

Appearances: W C Pyke and N T C Batts for the First Applicant
S K Green for the Second Applicant
D Jones and R M McMenamin for the Respondents

Judgment: 8 April 2022

JUDGMENT OF COOKE J

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[1] In this proceeding NZDSOS Inc, an incorporated society representing health practitioners who are opposed to vaccination (the first applicant), and NZTSOS, an incorporated society made up primarily of teachers and educators who are opposed to vaccination (the second applicant), challenge orders that were made under the COVID-19 Public Health Response Act 2020 (the Act) imposing mandatory vaccination for workers in the health and disability, and education sectors.

[2] The challenges have been partly addressed at earlier hearings of the Court. By judgment dated 12 November 2021 Palmer J heard and dismissed the claim that the requirement to be vaccinated as established by the COVID-19 Public Health Response (Vaccinations) Order 2021 (the Order) was not within the empowering provisions of the Act.[1] In addition, by judgment dated 12 November 2021 Palmer J dismissed an application for interim relief directed to the remaining claims.[2] The remaining claims — including the claim that the Order is invalid as it is not a reasonable and demonstrably justified limit of rights under the New Zealand Bill of Right Act 1990 (the Bill of Rights) — were heard by me in March and are the subject of this judgment.

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1 *Four Midwives, NZDSOS Inc and NZTSOS Inc v Minister for COVID-19 Response* [2021] NZHC 3064.

2 *NZDSOS Inc and NZTSOS Inc v Minister for COVID-19 Response* [2021] NZHC 3071.

[3] After the hearing before me the Prime Minister announced that the vaccine mandates imposed by the Order had been reviewed, and that a mandate would no longer exist for education workers, and would potentially be narrowed for health workers. I will address the significance of that announcement below.

The background

[4] The COVID-19 global pandemic has given rise for the need for governments around the world to introduce measures in an attempt to address its adverse effects. In New Zealand this has led to an exercise of power by the executive government that is arguably unparalleled in New Zealand's history. Certainly the extent to which the government has exercised control of what New Zealanders have been able to do in their everyday lives extends well beyond any other exercise of power in living memory.

[5] These circumstances put into stark focus the function of the Court. That is for at least two reasons. First, it is the constitutional role of the Court to ensure that the exercise of power by the executive remains within the bounds of the law. The rule of law underpins the legitimacy of democratic government. Secondly, the exercise of extraordinary powers can be particularly significant for minority groups who oppose the measures introduced. That is so here as the applicants represent those who are strongly opposed to vaccination, or at least mandatory vaccination. Yet vaccination, and mandatory vaccination have been regarded by the government as an integral part of the measures it has introduced in an attempt to minimise the harm caused by the pandemic.

[6] It is accepted by the Crown that the measures imposed by the Order limit the fundamental rights of affected persons, including those represented by the applicants, particularly the right to refuse to undergo medical treatment as provided under s 11 of the Bill of Rights. As I will explain in greater detail below, the legality of the measures introduced by the Order then turn on whether they involve a reasonable limit prescribed by law as is demonstrably justified in a free and democratic society under s 5 of the Bill of Rights Act. It is the role of the Court to ensure that this stringent test is met.

[7] The limitation on individual rights arising from executive orders did not begin with the vaccination requirements, however. It began with the nationwide lockdowns imposed under the Health Act 1956 from March 2020. In July 2020 a full Court of the High Court was convened to hear a challenge brought to the legitimacy of these measures in *Borrowdale v Director-General of Health*.[3] By judgment dated 19 August 2020 this challenge was largely dismissed. The full Court held, however, that the first nine days of the lockdown were not lawfully imposed, and involved an unlawful limitation of rights and freedoms. A declaration was made accordingly. That judgment was unsuccessfully appealed to the Court of Appeal.[4]

[8] Whilst the lockdown limited rights and came at very considerable social and economic cost, history may judge it to have been highly successful. New Zealand managed to effectively eliminate the presence of COVID-19 at this stage. This is in part because New Zealand communities were conscientious in acting for the greater good by complying with the lockdown requirements. But a lockdown could not last forever, and circumstances were quickly evolving. In *Borrowdale* the full Court observed that the exercise of powers to address the pandemic under existing legislation had temporal limits, and that:[5]

> … When a public health crisis is ongoing, the democratic nature of our constitution means that there comes a point when Parliament ought to pass bespoke legislation to ensure that critical policy decisions are made by ordinary Cabinet decision-making. That is, in fact, exactly what happened here, when Parliament enacted the COVID-19 Public Health Response Act 2020 on 13 May.

[9] The Act was passed on 13 May 2020, with the Bill introduced only the day before.

[10] The original form of the Act made no reference to vaccination, and it does not appear that measures including vaccination were contemplated on enactment. No vaccine had yet been developed, and neither does it appear to have been predicted by the Act. That is apparent from the Attorney-General's report on the compliance of the proposed legislation with the Bill of Rights. The report dated 11 May 2020 made no

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3 *Borrowdale v Director-General of Health* [2020] NZHC 2090, [2020] 2 NZLR 864.
4 *Borrowdale v Director-General of Health* [2021] NZCA 520.
5 *Borrowdale v Director-General of Health*, above n 3, at [102].

reference to compulsory vaccination, but did make reference to compulsory medical examination and testing, which was contemplated by the provisions, stating that the Bill "… does not require a person to undertake any particular ongoing form of treatment. In this way, the Bill continues to preserve the scope of personal autonomy and bodily integrity as far as is possible while maintaining public health".[6]

[11] Significant efforts were being made globally to find vaccines that were effective in preventing, or at least limiting COVID-19, however. A number of vaccines were ultimately developed and along with many other countries New Zealand gave approval for their use and introduced a programme to make the vaccine available to New Zealanders. A decision was made to primarily use the Comirnaty COVID-19 vaccine, commonly referred to as the Pfizer vaccine, in New Zealand. Provisional consent for its use under the Medicines Act 1981 was given in February 2021.

[12] This approval was challenged in the Court. In May 2021 Ellis J considered an application for interim relief in a judicial review challenge to the approval of the vaccine.[7] As in *Borrowdale* a legal problem was identified. The Court accepted the requirement of s 23 of the Medicines Act that a provisional approval be for a "limited number of patients" did not appear to be satisfied as the vaccine was being rolled out for all eligible adults. But Ellis J nevertheless concluded that the public and private repercussions militated against the grant of interim relief for a number of reasons, including that the vaccination programme was a key part of the country's plan to deal with COVID-19.[8] The application for interim relief was declined on that basis. Within a matter of days Parliament responded to the problem that the Court had identified by passing amending legislation.[9] Later in February this year Ellis J heard and dismissed a similar application directed to the Pfizer paediatric vaccine.[10]

[13] During the period when the government considered using vaccination as a measure to control an outbreak or spread of COVID-19 New Zealand remained COVID free. In March 2021 the Minister of COVID-19 Response decided that

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6 Hon Andrew Little "Consistency with the New Zealand Bill of Rights Act 1990: COVID-19 Public Health Response Bill" (2020) at [33].
7 *Nga Kaitiaki Tuku Iho Medical Action Society Inc v Minister of Health* [2021] NZHC 1107.
8 At [71].
9 Medicines Amendment Act 2021, s 23(1).
10 *MKD v Minister of Health* [2022] NZHC 67.

Cabinet should approve an amendment to 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".[11] By April the position had changed and a decision was apparently made not to amend the Act before making such an order. The view appears to have been taken that the provisions of the Act did not need to be amended before such an order could be promulgated.

[14] The Act was then used to implement what have come to be known as vaccine mandates. When the Order was first promulgated it only imposed a mandate on border workers. The first version came into effect on 30 April 2021, as later amended in July 2021.

[15] Once again the legality of the implementation of such measures was challenged before the Courts. The first challenge was heard by Churchman J in September 2021. In *GF v Minister for COVID-19 Response* he rejected arguments that the Order was ultra vires and/or irrational.[12] When doing so Churchman J referred to the views of the European Court of Human Rights in *Vavricka and Ors v The Czech Republic* in relation to mandatory vaccination of children attending pre-school facilities.[13] That decision did not concern vaccines developed to respond to COVID-19 but vaccinations against other infectious diseases. It nevertheless had significance. The Court held that such measures did not infringe against the rights under the European Convention. The European Court said:[14]

> The Court accepts that the exclusion of the applicants from pre-school meant the loss of an important opportunity for these young children to develop their personalities and to begin to acquire important social and learning skills in a formative pedagogical environment. However, that was the direct consequence of the choice made by their respective parents to decline to comply with a legal duty, the purpose of which is to protect health, in particular in that age group. As stated by the respondent Government, and by some of the intervening Governments, who rely on extensive scientific evidence … early childhood is the optimum time for vaccination. Moreover, the possibility of attendance at pre-school of children who cannot be vaccinated for medical reasons depends on a very high rate of vaccination amongst other children against contagious diseases. The Court considers that it cannot be regarded as disproportionate for a State to require those for whom

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11 See *Four Aviation Security Service Employees v Minister of COVID-19 Response* [2021] NZHC 3012 at [18].

12 *GF v Minister for COVID-19 Response* [2021] NZHC 2526.

13 *Vavricka and Ors v The Czech Republic* ECHR 47621/13, 8 April 2021.

14 At [306].

> vaccination represents a remote risk to health to accept this universally practice protective measure, as a matter of legal duty and in the name of social solidarity, for the sake of the small number of vulnerable children who are unable to benefit from vaccination. In the view of the Court, it was validly and legitimately open to the Czech legislature to make this choice, which is fully consistent with the rationale of protecting the health of the population. The notional availability of less intrusive means to achieve this purpose, as suggested by the applicants, does not detract from this finding.

[16] In October I then considered a further challenge brought by border workers in *Four Aviation Security Service Employees v Minister of COVID-19 Response*.[15] By that stage circumstances had further evolved. The new Delta variant of COVID-19 had emerged, and there was a fresh outbreak of that variant in Auckland leading to further lockdowns being employed in the Auckland region. I dismissed two key challenges: the first that the vaccine mandates implemented by the Order was ultra vires, and secondly that the mandates imposed a limit on the right to refuse medical treatment that was not reasonable and demonstrably justified in a free and democratic society. When doing so I said:[16]

> 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.
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> 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.

[17] In the meantime the government was reacting to the need to respond to the Delta variant. The Minister of COVID-19 Response, the Honourable Christopher Hipkins explains that in October 2021 Cabinet decided to move from an elimination

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15 *Four Aviation Security Service Employees v Minister of COVID-19 Response*, above n 11.
16 At [128] and [129].

strategy to a strategy of minimisation and protection. This contemplated an expansion of the vaccine mandates so that they were not solely directed to the places where the virus might enter New Zealand as was the case with border workers, but to other workplaces as part of a strategy to minimise its spread and the harm that it could cause. As early as August work had begun on developing a vaccine mandate in the health and disability sector and this carried through September and early October. The Minister explains that similar work had taken place in the education sector, mainly in October, and in connection with the perceived need to get children affected by localised lockdowns back into the school environment.

[18] A decision was then made by Cabinet on 11 October to proceed with such mandates, and the Minister then signed the order on 22 October 2021. It was introduced by amendment to the original Order through the COVID-19 Public Health Response (Vaccination) Amendment Order (No 3) 2021 (2021/325) with effect from 25 October. This extended the Order previously made in relation to border workers so that it covered the health, disability and education sector workers. Clause 7 of the Order, made under s 9 of the Act, materially provided:

> **Duty of affected person not to carry out certain work**
>
> An affected person must not carry out certain work unless they are –
>
> (a) vaccinated; or
>
> (b) an exempt person.

[19] The affected persons are identified by the definitions in s 4 and by sch 2. Schedule 2 was amended to include the following two groups:

> *Part 7: Groups in relation to health and disability sector*
>
> 7.1 Health practitioners providing health services to patients in person
>
> 7.2 Workers who carry out work where health services are provided to members of the public by 1 or more health practitioners and whose role involves being within 2 metres or less of a health practitioner or a member of the public for a period of 15 minutes or more
>
> 7.3 Workers who are employed or engaged by certified providers and carry out work at the premises at which health care services are provided
>
> 7.4 Care and support workers

…

Part 9: Groups in relation to affected education services

9.1 Workers over the age of 12 years who carry out work at or for an affected education service (including as a volunteer or an unpaid worker) and who—

(a) may have contact with children or students in the course of carrying out that work; or

(b) will be present at the affected education service at a time when children or students are also present

9.2 Providers of a home-based education and care service

[20] At this stage the definition of "vaccinated" required all the doses of the COVID-19 vaccine in sch 3 to be administered, which effectively mandated two doses of the Pfizer vaccine for most persons. Clause 7 was later amended in January 2022 to require a booster dose of the vaccine.[17]

[21] It is important not to view these measures in isolation, as they were part of an overall framework for responding to COVID-19. On 30 November the Minister promulgated the COVID-19 Public Health Response (Protection Framework) Order 2021 establishing other measures including mask wearing, restrictions on gathering size, and the use of vaccine passes at various settings. These can be understood to mandate other measures relevant to an overall regime for controlling COVID-19. They formed an important part of the controls in place, including at schools, hospitals and other similar places.

[22] In November 2021 Palmer J heard the first part of the challenges advanced in this proceeding along with a challenge brought by four midwives. He addressed whether such vaccine mandates were within the empowering provisions in ss 9 and 11 of the Act. Although the reasoning in *Four Midwives, NZDSOS and NZTSOS* is slightly different from that which I followed in *Four Aviation Security Service Employees* Palmer J reached the same conclusion that the measures were contemplated

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[17] By cl 11, COVID-19 Public Health Response (Vaccinations) Amendment Order 2022. See [106] below.

by the empowering provisions. He did not see a need to read down those provisions in light of the Bill of Rights Act. As he put it:[18]

> The s 6 interpretive direction requires, as far as possible, legislation to be interpreted consistently with the Bill of Rights. That requires reference to both the relevant right or freedom and to whether the limit is justified. The right to refuse to undergo medical treatment under s 11 of the Bill of Rights is engaged here. No order can be made under the empowering provision that limits the right unless it is reasonable, prescribed by law and can be demonstrably justified in a free and democratic society under s 5 of the Bill of Rights. If a limit in an order is so justified, s 6 does not require the usual purposive interpretation of the empowering provision to be narrowed to mean the order is outside its scope. That is the substantive position reached by the Supreme Court in *Hansen* and *New Health New Zealand*. It is not contradicted by the other cases referred to. It is consistent with bringing the full, balanced effect of the Bill of Rights to bear holistically on the interpretation of legislation.

[23] For this reason the key issue becomes whether the vaccine mandates are reasonable and a demonstrably justified limit on Bill of Rights rights.

[24] The Act was also amended at this stage. The first amendments were made by the COVID-19 Public Health Response Amendment Act 2021 on 19 November 2021. The second were made by the COVID-19 Response (Vaccinations) Legislation Act 2021 on 25 November 2021. Although neither set of amendments had been made when the Order challenged in this case was promulgated, they involved material changes to the overall scheme of the Act and the orders made under it. The first set of amendments added a series of additional purposes for which orders could be made under s 11 although these were not focused on vaccination. They also rearranged s 11. The new s 11(1) now provided:

> (1) The Minister or the 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:
>
> (i) To require persons to refrain from taking any specified actions or to take any specified actions, or comply with any specified measures, so as to contribute or be likely to contribute to either or both of the following:
>
> (i) preventing, containing, reducing, controlling, managing, eliminating, or limiting the risk of the outbreak or spread of COVID-19:

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[18] *Four Midwives, NZDSOS Inc and NZTSOS Inc v Minister for COVID-19 Response*, above n 1, at [50].

(ii) avoiding, mitigating, or remedying the actual or potential adverse public health effects of the outbreak of COVID-19 (whether direct or indirect):

[25] The new s 11(1)(b) then gave a list of examples of orders that could be made under (a) and new detailed provisions were added in s 11(1)(c)–(g). The second set of amendments added a series of powers that were focused on vaccination. They also introduced a new power in s 11AA of the Act. This was a power that could be exercised to introduce vaccine mandates for purposes other than those outlined in s 11. This power was available to the Minister of Workplace Relations and Safety rather than the Minister of COVID-19 Response.

[26] These two sets of amendments can perhaps be taken to respond to the views expressed in *Four Aviation Security Service Employees* and *Four Midwifes* that legislation be passed to directly authorise vaccine mandates, albeit that they did so somewhat obliquely.[19]

[27] The new power in s 11AA was then exercised to introduce vaccine mandates for the New Zealand Police and the New Zealand Defence Forces. These mandates were not introduced to prevent the spread of COVID-19, but to ensure the continuity of the public services provided by the Police and Defence Forces given the risk of absenteeism caused by the pandemic. In February this year I heard and then upheld a challenge to these orders in *Yardley v Minister for Workplace Relations and Safety*.[20] By that stage the Omicron variant of COVID-19 had emerged. I held that the limit on fundamental rights, particularly the right to refuse to undergo medical treatment, had not been demonstrably justified. Whilst COVID-19, particularly its more infectious Delta and Omicron variants, posed a threat to the continuity of those workforces I was not persuaded that greater continuity of those services was secured by the mandate. The very high rates of vaccination arising from the existing vaccination policies applicable to those workforces, and the very small number of employees affected by the order when it was introduced, meant that the Crown had failed to show that the measure was demonstrably justified in a free and democratic society.

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19 *Four Aviation Security Service Employees v Minister of COVID-19 Response*, above n 11; *Four Midwives, NZDSOS Inc and NZTSOS Inc v Minister for COVID-19 Response*, above n 1, at [74]-[75].

20 *Yardley v Minister for Workplace Relations and Safety* [2022] NZHC 291.

[28] This decision also referred to the potentially significant change in circumstances arising from the Omicron variant of COVID-19 in particular. Omicron appeared to be a much more transmissible variant of the virus, albeit with what appeared to be more moderate effects for most of those who contracted the illness. Moreover questions were arising on the continued effectiveness of vaccination to meaningfully control the spread of the virus.[21]

[29] It was in these circumstances that I heard this challenge in early March. The evidence filed by the parties sought, at least to some extent, to keep apace with the rapidly developing circumstances, but it was not possible to do so comprehensively. This has implications for the present challenge, for the reasons I will explain below.

[30] The Minister explained in his affidavit of 3 March that the vaccine mandates established by the Order were subject to review. He also said that advice had been commissioned from the Strategic COVID-19 Public Health Advisory Group chaired by Professor Sir David Skegg. Following the hearing of this challenge the Prime Minister made an announcement at a press conference on 23 March. She said that the vaccine mandate for the education sector would be revoked, and that the scope of the mandate for the health and disability sector would be reviewed and potentially narrowed. Counsel for the respondents have subsequently filed a memorandum dated 29 March confirming that the Prime Minister's statement represents the position of the Crown in this proceeding quoting the Prime Minister's words at the press conference concerning vaccine mandates in the following terms:

> As vaccination rates increased, we reached out to Professor David Skegg and the Public Health Advisory Group for his advice on their future use. Their advice was clear, stating: "The case for or against is now more finely balanced because of our relatively high vaccination coverage and increasing natural immunity, as well as the apparent lowering of vaccine effectiveness against transmission of the Omicron variant. While vaccination remains critically important in protecting New Zealanders from Covid-19, we believe that several of the vaccine mandates could be dropped once the Omicron peak has passed". [*The Prime Minister having indicated that it was anticipated that it would have passed by around 5 April*] And so, on that basis and in line with the Public Health Advisory Group advice, the Government will not require mandates to be in place for education, police, and defence workforces and those businesses operating vaccine passes, from 11.59 p.m. Monday, 4 April. Whether or not these workplaces will continue to need to be vaccinated to do

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21 At [91].

> their work will be a decision for their employers or those otherwise responsible for those workforces.

[31] The memorandum advised that this decision had been made by Cabinet on 21 March and that "at the same meeting, Cabinet also decided that the vaccination mandate for health and disability workers should remain in place but consideration will be given as to whether its ambit should now be narrowed".

[32] In a memorandum of counsel for the second applicant dated 24 March (following the Prime Minister's announcement) counsel for the second applicant raised a number of matters, including that the second applicant wished to continue with its claims, including the claim that the right to be free from medical treatment was an absolute right.

[33] As I see it the second applicant's claims should still be determined, including because of the potential for relief being granted by the Court that may have an impact on existing employment issues.

[34] The impact of the announcements is less significant on the claim by the first applicant, but still important as it is a formal record of the Crown's view that the scope of the vaccine mandate in that sector needs to be reviewed.

Nature of the claims

[35] Although there are additional matters of detail that I will address later below, the arguments advanced by each of the applicants involve three, or possibly four main grounds of challenge:

(a) that the right to refuse medical treatment affirmed by s 11 of the Bill of Rights is an absolute right not subject to any limitations under s 5, and the Order ought to be set aside as invalid;

(b) that the Crown cannot, or can no longer show that the Order involved a reasonably limit on this right that is demonstrably justified in a free and democratic society in accordance with s 5;

(c) that the Order is unreasonable and/or irrational and ought to be set aside. This argument is likely subsumed within (b) above;

(d) that the exemption criteria are unreasonable, irrational or being applied overly rigidly and the Order ought to be set aside, or other appropriate relief granted as a consequence.

[36] A large number of affidavits have been filed by the applicants. A number of health professionals, including doctors and dentists, have given evidence describing their objection to the vaccine mandate, the reasons why they do not wish to be vaccinated, and the adverse impact upon them arising from the mandate. A number of affidavits from experts have also been filed, including from:

(a) Associate Professor Byram Bridle (an immunologist and virologist at the University of Guelph, Ontario);

(b) Professor Nikolai Petrovsky (a specialist in vaccine related immunology and vaccine developer of Flinders University, South Australia);

(c) Professor Norman Fenton (a Professor of Risk Information Management at the University of London); and

(d) Dr Geoffrey Cramp (the Medical Officer of Health of the Waikato District Health Board).

[37] Their evidence is particularly relevant to the arguments directed to whether mandatory vaccination is demonstrably justified, although it may have indirect relevance to the other claims. I did not understand that Professor Fenton's evidence, which is of more limited scope, was a particular focus of the applicants' arguments.

[38] A very large number of affidavits have been filed by teachers and other education workers. These affidavits explain the individual circumstances affecting particular teachers, their schools or education centres, and the affected communities. This evidence attempts to address the position of each education region of

New Zealand. It also explains the reasons why particular education workers do not wish to be vaccinated, and the adverse impacts of the vaccine mandate for them, and for associated communities. The second applicant also relies on the expert evidence filed by the first applicant. The second applicant generally advances claims falling within the same categories described above, although there are additional elements to consider.

[39] The respondents rely on affidavits from the Minister for COVID-19 Response, Dr Ashley Bloomfield (the Director-General of Health), Dr Ian Town (the Ministry of Health's Chief Science Advisor), Ms Rachel McKay (the Group Manager of Operations and the National Immunisation Programme, Ministry of Health) and Ms Helen Hurst (Head of COVID-19 Response within the Ministry of Education).

Is the s 11 right an absolute right?

[40] I deal first with the argument advanced by Mr Pyke, supported by Ms Green, that the right in s 11 is absolute and not capable of justified limitation in accordance with s 5 of the Bill of Rights. Section 11 provides:

> **11 Right to refuse to undergo medical treatment**
>
> Everyone has the right to refuse to undergo any medical treatment.

[41] There are two preliminary points emerging from Mr Pyke's arguments. First, the applicants sought a declaration of inconsistency as part of the relief arising from this ground of challenge. Such relief would not have been apposite. Declarations of inconsistency are relevant only when it is the legislation itself which is inconsistent with the Bill of Rights. Here the Act itself does not impose a vaccine mandate. The mandate is imposed by subordinate orders made under its provisions. For the reasons I explain more fully below, if an order is inconsistent with the Bill of Rights, including following any relevant justified limitation enquiry under s 5, then it is unlawful and can be set aside.

[42] Secondly, Mr Pyke noted that his argument might also be relevant to the first ground of challenge already addressed by Palmer J, and possibly on appeal against that decision. There may be a basis for that view based on the dissenting judgment of

Elias CJ in *New Health New Zealand Inc v South Taranaki District Council*.[22] But I respectfully see the argument as falling more comfortably within this part of the challenge. If the applicants are right and the s 11 right cannot be subject to limits because of the nature of that right then the Order should be set aside as unlawful subordinate legislation. Moreover the argument for an absolute right may be rejected, but an argument that it is a right subject to only very confined limits may be accepted. The scope of any limitations are most appropriately dealt with in this phase of the case.

The arguments

[43] Both Mr Pyke and Ms Green argued that the right in s 11 was absolute. Mr Pyke pointed out that in international human rights instruments it is a right that more frequently forms part of the right to be free from torture, or cruel or inhuman treatment, which is incorporated under s 9 of the Bill of Rights.[23] He argued that s 11 had the same status as the right in s 9, and that the analysis of the Supreme Court in *Fitzgerald v R* based on earlier authority that no limitation of the s 9 right could arise applied equally to the s 11 right.[24]

[44] Mr Pyke also referred to international jurisprudence recognising that the right to refuse medical treatment was a corollary of informed consent, and that it had its roots in the notions of self-determination and the inherent dignity of the human being.[25] These sentiments are also reflected in New Zealand law, including in ss 6 and 7 of Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, and the ethical codes for health practitioners. It was also a concept generally contemplated as a fundamental one in medical health, reflected in the Universal Declaration on Bioethics and Human Rights referred to in Dr Cramp's evidence.[26] He relied on the judgment of Pankhurst J in *Corrections v All*

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

23 For example International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976), art 7; see also Charter of Human Rights and Responsibilities Act 2006, s 10.

24 *Fitzgerald v R* [2021] NZSC 131, (2021) 12 HRNZ 739 at [160].

25 *Airedale HS Trust v Bland* [1993] AC 789 (HL); *BST Holdings v Occupational Safety and Health Administration*, United States Court of Appeals for the fifth circuit, No 21-60845, 12 November 2021.

26 The United Nations Education Scientific and Cultural Organisation (UNESCO) *Universal Declaration on Bioethics and Human Rights* SHS/EST/BIO/06/1, SHS.2006/WS/14 (October 2005).

Means All in which the Court declined to give a declaration that prison authorities could force a prisoner on hunger strike to receive medical treatment in the form of hydration and nutrition given the fundamental importance of the right in s 11.[27] Pankhurst J indicated he was not persuaded that a justification existed to limit the prisoner's right in s 11. In doing so he said:[28]

> It seems to me that New Zealand has plotted its own course, at least in terms of the emphasis it has accorded to informed consent. Counsel's researchers revealed no other country which has a provision equivalent to s 11, enshrining the right to refuse medical treatment. In consequence, cases in other jurisdictions which have had to consider this very issue do so, not by reference to an express provision of their constitution or charter, but by reference to other more general of their fundamental rights.

[45] In her supporting submissions Ms Green referred to what she called "cultural afront" arising from the vaccine mandate. Included within that argument was reliance on principles of tikanga, including that of personal tapu, which recognised that the concepts of personal self-determination and mana were of high importance.[29]

Assessment

[46] I do not accept the arguments for the applicants. In my view the right in s 11 can be subject to demonstrably justified limits.

[47] There is no support for the proposition that a right to be free from medical treatment is an absolute right in the international material provided to me. Indeed, as indicated, the European Court of Human Rights has recently upheld a requirement for those attending early education centres to be vaccinated against other illnesses for the protection of others in *Vavricka and Ors v The Czech Republic*.[30]

[48] New Zealand separated out this right from the other associated rights when enacting the Bill of Rights. As Pankhurst J indicated in *All Means All*, New Zealand thereby charted its own path in separating out a right to refuse medical treatment. In other human rights instruments this right is subsumed within other more generally

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27 *Corrections v All Means All* [2014] NZHC 1433, [2014] 3 NZLR 404.
28 At [46].
29 See Hirini Moko *Living by Māori Values – Tikanga Māori* (Huia Publishers, Wellington, 2003) at [49]–[51].
30 *Vavricka and Ors v The Czech Republic*, above n 13.

expressed rights. In so doing the Bill of Rights distinguishes this right from the right not to be deprived of life (in s 8), the right not to be subject to torture or cruel treatment (in s 9) and the right not to be subjected to medical or scientific experimentation (in s 10). The rights in ss 8–10 can be seen as more absolute in character, as the Supreme Court has recently reiterated with respect to s 9 in *R v Fitzgerald*. But although the right in s 11 can be seen as belonging to the same family of rights, its separation out from the other rights, particularly the right to be free from medical or scientific experimentation in s 10, has significance. When proposing a separate right in what was to become s 11 the authors of the White Paper said:[31]

> This provision has no equivalent in the International Covenant, nor in any other international human rights instrument. It enacts as a general principle that everyone has the right to refuse to undergo any medical treatment. This right is of course subject to Article 3, but it is anticipated that this would permit persons to be treated against their will only where this is necessary to protect the health and safety of other persons, and not simply where their refusal of treatment will detrimentally affect their own health. …

[49] The fact the authors were of the view that the right was "of course" subject to what is now s 5 is significant. By comparison the right reflected in what is now s 10 was not noted by the authors as being subject to s 5.[32] In *Four Aviation Security Service Employees* I rejected the argument that the vaccine mandate limited the right in s 10.[33]

[50] The view that the right in s 11 can be subject to demonstrably justified limits was also determined by the majority of the Supreme Court in *New Health*.[34] Here O'Regan and Ellen France JJ found that the right to be free from medical treatment was limited by the fluoridation of water supplies, but concluded that this limitation was demonstrably justified in a free and democratic society under s 5.[35] Glazebrook J agreed with this conceptual framework, but declined to address the question of justification under s 5 on the facts as it could depend on local conditions.[36] The two dissenting judgments did not directly address this question — Elias CJ concluded that

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31 Geoffrey Palmer *A Bill of Rights for New Zealand: A White Paper* [1984–1985] 1 AJHR A6 at [10.166].

32 At [10.164]–[10.165].

33 *Four Aviation Security Service Employees v Minister of COVID-19 Response*, above n 11, at [31]–[36].

34 *New Health New Zealand Inc v South Taranaki District Council*, above n 22.

35 At [101]–[144].

36 At [176].

fluoridation could not be imposed by subordinate legislation at all in the absence of much clearer legislation, and William Young J concluded that the right to refuse medical treatment was not engaged by the fluoridation of water supplies.

[51] The decision in *New Health* is accordingly in direct conflict with the applicants' submission. The majority found that the s 11 right could be subject to s 5 limits. I am bound by that decision. It is also inconsistent with my two previous judgments in *Four Aviation Security Service Employees* and *Yardley*,[37] and with Churchman J's judgment in *GF v Minister for COVID-19 Response*.[38]

[52] That justified limits on the right in s 11 can arise is demonstrated by the current circumstances. The Crown properly acknowledges the right in s 11 is being limited by the Order. But the affected workers are not being literally compelled to receive a medical treatment. They are not being physically restrained and inoculated. By contrast in *All Means All* the authorities sought to so compulsorily treat a prisoner. The workers here are being subject to considerable economic and social pressure to either accept vaccination or face dismissal from their employment. But they still have the right to decline. As I indicated in *Yardley* the pressure must be regarded as considerable partly because the right to retain existing employment is also one of significance recognised in domestic law, and reflected in international instruments.[39] That right is also being limited by the Order as a consequence. The limitation arises for a public benefit of a similar kind to that recognised by the European Court in *Vavricka*.[40] This seems to me to be the kind of potential limitation of the s 11 right that the authors of the White Paper foreshadowed.

[53] What the argument advanced by the applicants does support, however, is the view that the right in s 11 is well recognised in both legal and medical terms as being fundamental. It is associated not only with the concept of personal autonomy that is at the heart of the relationship between the state and the individual, but also the concept of informed consent that is deeply embedded in the principles of medical ethics and

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37 *Four Aviation Security Service Employees v Minister of COVID-19 Response*, above n 11 and *Yardley v Minister for Workplace Relations and Safety*, above n 20.
38 *GF v Minister for COVID-19 Response*, above n 12.
39 At [44]–[46].
40 *Vavricka and Ors v The Czech Republic*, above n 13.

practice. It is true that the vaccinators involved in the nationwide vaccination programme should still have observed the principles of informed consent when administering the vaccine. But the pressure created by the mandates, and the general circumstances, have plainly reduced the significance that is otherwise so strongly placed on informed consent. I have sympathy for some of the views expressed by the applicants' experts about this in that context.

[54] What this means is that there is a very significant evidential burden placed on the Crown to demonstrate that the measures implemented by the Order are reasonable, and demonstrably justified in a free and democratic society. I nevertheless remain of the view that this case turns on the question of justified limits, just as it did for *Four Aviation Security Service Employees* and *Yardley*.

[55] Before turning to that question I note there was some reference to other rights in the materials before the Court. But they have not been the focus of argument, and I do not address them as any relevance they may have will not likely change the outcome of this proceeding.

Is the limit of the right by the Order demonstrably justified?

[56] I accordingly turn to what I again apprehend to be the key issue in this case — whether the limitation of the right under s 11 of the Bill of Rights is demonstrably justified in a free and democratic society under s 5. In order to do so I need to consider a number of matters.

How the Bill of Rights directly controls the exercise of power

[57] I begin by reiterating the line of analysis followed in *Four Aviation Security Service Employees*, *Yardley* and also by Palmer J in the first stage of the present case explaining why the legality of the Order depends on the question of justified limitation under s 5. The parties did not advance submissions disagreeing with the analysis undertaken in those cases, but I set it out for reasons of transparency.

[58] In a line of cases beginning with *Drew v Attorney-General* through to *New Health New Zealand Inc* 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 an express provision in the empowering legislation.[41] If Parliament intends to authorise the making of regulations or other orders that are in conflict with fundamental rights then it needs to do so expressly and unambiguously. Otherwise this is treated as an inherent limit on the power to create that subordinate legislation. As I said in *Four Aviation Security Service Employees* it is as if the empowering provision here expressly stated "provided that no order can be made that is inconsistent with the New Zealand Bill of Rights Act 1990".[42]

[59] There is clearly no legislative intention here to authorise orders in conflict with the Bill of Rights. That is shown by a number of the provisions of the Act, most notably s 9(1)(a) which requires the Minister for COVID-19 Response to assess and conclude that an order made does not limit, or is a justified limit on the rights in the Bill of Rights.

[60] The fact that the Minister must reach that conclusion provides an additional level of protection. But it does not replace the requirement that an order be consistent with the Bill of Rights. The Minister must ask and answer this question. The Minister's decision can be challenged on what can be described as conventional judicial review grounds — for example that he had not asked himself the right questions, failed to consider the mandatory relevant considerations, or took into account irrelevant considerations.[43] But the additional prerequisite for the lawful exercise of power — that the Order is consistent with the Bill of Rights — is a further, objective, requirement. It necessitates an assessment by the Court. The Court must consider whether the measures imposed by the Order limit the rights in the Bill of Rights and, if they do, whether that limit is demonstrably justified under s 5. In the present case the acknowledgement by the Crown that the measures in the Order limit the s 11 right means that the question of the legality of the Order depends on whether that limitation is demonstrably justified under s 5.

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41 *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 22 at [294]–[297].

42 *Four Aviation Security Service Employees v Minister of COVID-19 Response*, above n 11, at [56].

43 These types of challenges were advanced, and dismissed, in *GF v Minister for COVID-19 Response*, above n 12 at [95]–[127], and *Four Aviation Security Service Employees v Minister of COVID-19 Response*, above n 11, at [130]–[142].

[61] This kind of challenge is accordingly different from most judicial review challenges as it involves less focus on the reasoning of the decision-maker. Here the question is whether the measures implemented by the Order are lawful, and this depends on the Court's assessment on whether the Crown has established that the limitation of rights involved is demonstrably justified in a free and democratic society under s 5. It is still ultimately a challenge to a decision but with less focus on the reasoning of the decision-maker at the time. It is not so much the decision that is being scrutinised as the measure itself.

[62] Neither is the Court limited to assessing the matters that were before the Minister of COVID-19 Response when he signed the Order. The Crown is expected to file evidence, and advance submissions, directed to whether the measure in the Order is demonstrably justified. That is so whether or not they were before the Minister at the time. It is partly for this reason that I see reduced room for the concept of deference.[44] Strictly speaking there is nobody to defer to as it is the measure itself, rather than the decision implementing it, that must meet the standards set by the Bill of Rights.

[63] In addition, the Court is not inherently confined to the circumstances in existence at the time the Order was made. If there are developments since that time that mean that the Order is no longer demonstrably justified then the Court would likely be obliged to make that finding and set it aside. That is a consequence of the constitutional nature of review in this kind of case.[45] The circumstances here are very fast moving, and it is part of the applicants' challenge that the developments in relation to Omicron in particular mean the mandate is not, or is no longer justified. Indeed the Crown itself has now revoked one of the mandates relevant to these proceedings, and announced it is reviewing the scope of the other, as a consequence of these developments.

[64] But whilst the Court is not confined to the circumstances at the time the Order was made, it is also not possible for the Court to review matters contemporaneously.

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44 See *Yardley v Minister for Workplace Relations and Safety*, above n 20 at [61]–[64]; and *Four Aviation Security Service Employees v Minister of COVID-19 Response*, above n 11, at [80]–[86].

45 See M Ponomarenko *Changed Circumstances and Judicial Review* (2014) 89 NYULR Rev. 1419; and *Yardley v Minister for Workplace Relations and Safety*, above n 20, at [80].

The inherent nature of Court proceedings, and the requirements for procedural fairness, will mean that the Court can only take into account developments that can be addressed in a procedurally fair manner. There are also limits on the Court's ability to make findings on contested matters that may be important to the question of whether the measures are demonstrably justified. I will return to this important issue again below.

Framework for assessing justification

[65] I turn next to explain how the Court addresses whether the measures here are or are not demonstrably justified.

[66] The existence of a separate justified limitations provision in s 5 of the Bill of Rights is unusual in international terms. A similar provision exists in the Canadian Charter, but most human rights instruments are not structured in this way. This structure has the advantage of creating greater simplicity as there is no need to interpret rights in a manner that caters for such limitations. Overseas authorities need to be considered with care given this distinctive feature of the New Zealand regime.[46]

[67] The approach to assessing justified limits under s 5 has traditionally involved the steps described by Tipping J in *R v Hansen* which in turn applied the approach of the Supreme Court of Canada in *R v Oakes*.[47] This involves addressing the following questions:[48]

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

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

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

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46 See A & P Butler *The New Zealand Bill of Rights Act – A Commentary* (2nd ed, LexisNexis NZ Ltd, Wellington 2015) at [6.22].

47 *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 at [108]-[111]; *R v Oakes* [1986] 1 SCR 103.

48 *R v Hansen,* above n 47, at [64]; *R v Chaulk* [1990] 3 SCR 1303 at pp 1335 – 1336.

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

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

[68] This should not be applied as a rigid test, however. Rather it is a framework for assessing whether the measure is demonstrably justified in a free and democratic society. Many of these questions seem to me to shade into one another. And the particular circumstances before the Court may warrant a line of analysis that is not particularly emphasised by the above steps. What is required is careful scrutiny of the justification for the measure in question. Or as I put it to Mr Jones in argument, the Court will "apply the blowtorch" and then examine if the measure has survived.

[69] In the present case, for example, the key areas of contest arise more from factual disputes — and in particular in relation to the safety and efficacy of the vaccine, and the practical implications of the mandate. To some extent the resolution of those disputes answer the questions posed by the above steps, albeit not entirely. For example, if the applicants are correct that the vaccine is ineffective in limiting the spread of COVID-19 and/or it is unsafe, then the mandate will not likely be demonstrably justified. On the other hand if the Crown's evidence is accepted and vaccination significantly reduces the spread of COVID-19 then a case for a demonstrably justified limitation arises, although it may still be necessary to address the kind of steps described above to ensure the specific measure is justifiable.

Justification for the health sector mandate

[70] I deal first with the Crown's justification for the mandate in the health and disability sector. Two key justifications are advanced in the evidence of the Minister and Director-General, and were the focus of the Crown's submissions:

(a) that vaccination assists in limiting the risk of transmission from health and disability workers to those for whom they care, and onwards into the wider community; and

(b) that full vaccination of all such workers limits the risk of absenteeism in this workforce at a time when the sector will be under strain.

[71] It seems to me that the first of those factors is the more important one. There are a series of matters relevant to this workforce that I accept are significant:

(a) First, health and disability workers may be at heightened risk of being infected and transmitting COVID-19 given that close contact, including with those who may be unwell, is part of the delivery of most health and disability services.

(b) Secondly, many of those that seek such services have other illnesses and conditions that may make them more vulnerable to COVID-19, or be in close contact with such persons. A hospital is a location, for example, that has patients with other illnesses and conditions that make them vulnerable, and where a more pressing need to maximise protection from COVID-19 exists.

(c) Thirdly, many who access health services do so out of a pressing need and without the ability to make choices. A patient admitted to hospital may not be able to make choices as the circumstances compel them to enter that environment. In those circumstances patients can reasonably expect that all steps reasonably available to minimise the risk of them being exposed to COVID-19 have been taken. Such patients can reasonably expect a zero tolerance approach. That is also so for those who attend health services more regularly. A cancer patient attending for a chemotherapy course, or a patient attending for regular dialysis, can reasonably expect the health professionals they engage with to have taken all available measures to reduce the COVID-19 risks.

(d) Finally, it is of vital importance that public confidence in the delivery of health services remains high, particularly during a pandemic. So for the health sector adopting a zero tolerance approach, and being seen to have adopted that approach, is of importance to the overall system.

[72] These arguments are less persuasive for some health and disability workers covered by the mandate, however. Many of the members of the first applicant who bring this challenge are dentists, and some are general practitioners. A visit to a dentist, or other health and disability workers who operate more autonomously, may not involve patients accessing health services in a state of vulnerability, or with diminished ability to make choices. It may not totally exclude the operation of factors of this kind as those who access services of their general practitioner or dentist may still legitimately expect a risk minimisation approach. I note that unvaccinated general practitioners are able to consult with patients by remote means.

[73] Mr Batts argued for the first applicant that it was necessary to undertake the kind of analysis that the Court identified in *Yardley* to ascertain whether the mandate was demonstrably justified for this sector.[49] In particular it would be necessary to identify whether the vaccine mandate materially changed the vaccination rates before it could be shown that it was justified. The evidence shows that the voluntary vaccination rates were high, so that the mandate might achieve little in terms of any additional protection. He pointed out that no such analysis had been undertaken, and referred to the evidence of Dr Cramp who had indicated in broad terms the kind of assessment that could have been undertaken.

[74] I agree that such an assessment could be relevant, but I do not accept that this was a pre-requisite for a demonstrably justified limit. The vaccine mandates in issue in *Yardley* were implemented for a different purpose — to ensure the continuity of the workforces. That inherently involved a question of numbers — what did the mandate actually achieve in terms of the continuity of the workforces? But the reason for this mandate was different. It is based on inhibiting the spread of COVID-19, ensuring the availability of critical health services, and sustaining the public confidence in those services during the pandemic. A more refined assessment could have been relevant to the justification for the measure, but I do not accept it was a pre-requisite. A zero tolerance approach may still be justified, particularly given the fact those accessing critical health services will frequently be vulnerable, and often unable to make choices.

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[49] *Yardley v Minister for Workplace Relations and Safety*, above n 20.

[75] I am less convinced of the Crown's alternative reason for saying the measure is justified in the health sector — to ensure the continuity of health services by making sure that the workers are not absent because of COVID-19 illness. That is more similar to the kind of justification for the mandate in issue in *Yardley*. The justification only has substance if the mandate pressured health workers to vaccinate who would not otherwise have done so. If health workers were prohibited from working because of the mandate then it can hardly be argued that the mandate is justified because it limited their absenteeism. I accept that this justification may have required a stronger evidential basis before it could be seen as having significance. That is not apparent on the evidence before the Court. But the other reasons for the mandate do not require such an analysis.

[76] The justifications that I do accept have real significance still depend on certain factual matters that are in dispute — principally whether mandatory vaccination does in fact diminish transmission of the virus, whether it is safe, and whether there are other adverse impacts of the mandates that outweigh any such benefits. I address those factual disputes below before reaching final conclusions.

Justification for education sector mandate

[77] The justification for the existence of a mandate in the education sector is similar to, but not the same as the health sector. Again there were two interrelated justifications advanced:

(a) that schools and other facilities are places of regular gatherings of people and that this creates a risk of community transmission which should be minimised; and

(b) such an environment creates a risk to the children attending schools and education facilities, again warranting a risk minimisation approach.

[78] In relation to the first factor, I accept the evidence from the Minister that it was important that students be able to physically attend schools and other education facilities. The periods of lockdown, including the more recent lockdowns in the

Auckland region, compromised learning and development. There was accordingly a pressing need to get the students back into a physical environment.

[79] In common with the health sector, such physical attendance effectively created an environment where children and others were required to attend social gatherings of relatively high numbers of people. There is a degree of necessity or compulsion in attending such gatherings. These gatherings would be taking place daily, or at least regularly during the week. Social gatherings of that kind present a risk of community transmission. I accept the evidence of Dr Town and Dr Bloomfield that studies show that transmission does occur within school environments, although mostly on an adult to adult and adult to child basis rather than child to child. Dr Town explained that evidence was emerging that the rate of community transmission from schools was no different from community transmission generally. But it still remains a potential transmission point for the community more broadly.

[80] I also accept that it is relevant to take into account the risk to the children themselves. Whilst paediatric vaccination is now available it is not suggested that children should be required to be vaccinated to attend education facilities. But I do not accept that the risk the virus presents to the children themselves is a particularly strong factor. The evidence shows that COVID-19 is generally not a severe illness for children. That is a point emphasised by Professor Bridle in his evidence. It is also noteworthy that child to child transmission does not seem to be as significant as adult to adult or adult to child transmission. Having said that it needs to be remembered that there will be some children attending education facilities that will have underlying health conditions or other vulnerabilities. It may also be that long COVID is a factor for some children. So I accept the protection of the children remains a relevant part of the potential justification for a mandate. But the main public benefit arising from the vaccine mandate in the education sector was not so much the protection of children, but the protection of the community that the children then interact with. So it existed primarily to potentially reduce the prospect of the school being a transmission point for a disease that could affect the carers, parents and grandparents of those who attend the schools, and then the wider community.

[81] I see the potential justification for the mandates here as less compelling than in the health sector, however. There may still be a basis to say that a risk minimisation, or zero tolerance approach was appropriate. But there are also alternatives that are more rights compliant. For example a requirement for unvaccinated teachers to stay home if unwell, to have daily rapid antigen testing in the school, and to follow the other measures such as mask wearing and social distancing might be regarded as an alternative set of measures that provides adequate protection. As Tipping J's list of questions from *Hansen* suggests, if there are other more rights compliant ways of achieving the outcome, a measure may not be justified.

[82] In any event, as with the health and disability sector there are factual disputes that are important when assessing the Crown's justification for the mandate. As with the health and disability sector they involve the effectiveness of the vaccine to inhibit the spread of COVID-19 (particularly the Omicron variant), the safety of the vaccine, and the adverse effects arising from the mandate which are said to be greater than the public benefit obtained by the mandate. Again I will address these disputed issues before reaching final conclusions.

The contested issues

[83] In order to assess whether the mandates are justified I need to make findings on factual matters that have been placed in issue by the evidence that has been filed by the applicants. As indicated the disputes appear to arise in three main areas:

(a) the extent to which vaccination inhibits the spread of COVID-19, particularly in light of the Omicron variant;

(b) the extent to which the Pfizer vaccine has safety concerns; and

(c) whether there are adverse effects from a mandate that outweigh any public benefit in vaccination.

The evaluation of the expert evidence

[84] Before addressing these three matters there is a preliminary point of significance. It is an essential element of the Crown's contention that both mandates

are, or were justified, that vaccination is safe, and that it materially reduces the spread of COVID-19. This is disputed by the applicants who have filed evidence from four witnesses with relevant expertise, with the views of Professor Bridle, Professor Petrovsky and Dr Cramp being relied upon in particular. In those circumstances it is appropriate to first address what the Court's approach should be when there are contested questions of expert evidence of this kind in a judicial review proceeding.

[85] First, the Crown has the burden to demonstrate that a measure that limits a fundamental right is demonstrably justified under s 5. As I indicated at [54] above, given the fundamental nature of the right in s 11, the Crown has a reasonably high threshold to meet here.

[86] The Crown has provided evidence to support the justification which is challenged by the applicants. The High Court is accustomed to dealing with issues of contested expert evidence, sometimes in highly technical areas. It is required to make findings on such contests in the civil cases before it. It has well-established procedures to do so. There is the code of conduct for expert witnesses in Schedule 4 of the High Court Rules 2016. Conferral between experts is often directed, and the experts are often cross-examined at trial. It is not common for contests of expert evidence to be central to a judicial review proceeding however, and it is uncommon to have cross-examination in judicial review. But leave to cross-examine can be granted if it is necessary to fairly address a claim for judicial review.[50]

[87] The present case might have been a case where cross-examination could have been appropriate. There is plainly a contest of expert evidence between Doctors Town and Bloomfield on the one hand, and Professors Bridle and Petrovsky and Dr Cramp on the other. No application was made by the Crown to cross-examine the applicants' expert witnesses. Initially the first applicant made an application to cross-examine Dr Town, but that application was not pursued. The second applicant pursued an application to cross-examine the Minister and Dr Bloomfield, but by minute dated 1 March 2022 I declined that application as I was not satisfied that it met the standards required for cross-examination in judicial review. The proposed cross-examination of

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50 As summarised in *Geary v Psychologists Board* [2009] NZSC 67, (2009) PRNZ 415.

the Minister and of Dr Bloomfield was more wide-ranging in nature and not focused on the disputed questions of medical science that are potentially important to this case.

[88] Neither was there any conferral between the expert witnesses which may have been appropriate if the Court was to make findings on some of the more technical questions in issue. It can also be observed that the affidavit evidence was not directed to precise questions on which the experts gave opinions. The applicants' expert evidence involved more broad-ranging expressions of opinion about COVID-19 vaccination, including the Pfizer vaccine. Neither were the written or oral submissions of the applicants focussed on an analysis of the issues arising from the expert evidence and the conclusions that the applicants wished me to draw based on that evidence.

[89] There is a further significant factor. The respondents did not file independent expert evidence addressing the questions that had been addressed by the applicants' expert witnesses. For example, the Crown did not file any evidence from an expert epidemiologist. It limited itself to evidence from the Director-General of Health, Dr Bloomfield, and the Ministry's Chief Science Advisor, Dr Town. In addition the evidence filed by the Crown did not seek to respond to all the issues the expert evidence filed by the applicants addressed. The Crown's evidence did engage on some issues — for example the safety of the Pfizer vaccine — but many of the opinions expressed by the applicants experts were not responded to. Rather Drs Bloomfield and Town put forward their own views explaining why the vaccine was safe and effective. In effect I had two sets of expert evidence, effectively in parallel, on many of the important issues rather than evidence that directly responded to each other.

[90] All of this means that there is considerable difficulty involved in the Court making definitive findings on the disputed questions. In *New Health New Zealand Inc v South Taranaki District Council* the Supreme Court referred to the disputed issues of science in relation to fluoridation that arose in that case. There Ellen France and O'Regan JJ said:[51]

> It is obvious that the scientific evidence relating to fluoridation is contentious, in the sense that even apparently authoritative studies as to the benefits and detriments of fluoridation are called into question in other studies, in many cases on the grounds that the writers are biased. The Court is not in a position

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51 *New Health New Zealand Inc v South Taranaki District Council*, above n 22, at [121]–[122].

> to unpick these disputes nor is it able to determine whether particular scientific reports are scientifically robust. It can, however, note that the benefits of fluoridation are considered to be significant and the detriments insignificant by the World Health Organization and the Ministry of Health. It can also have regard to the fact that fluoridation of drinking water is sanctioned by law and actually occurs in a number of free and democratic countries with which New Zealand compares itself including Australia, Canada, the United States of America and the United Kingdom.
>
> Against that background, we consider the Court of Appeal was right not to attempt a definitive ruling on the scientific and political issues. We will undertake a broad assessment with a view to determining whether the evidence provides a proper basis for concluding that the limitation on the s 11 right resulting from fluoridation was justified.

[91] I will approach this case adopting the same broad assessment approach for similar reasons. This will involve considering the Crown's evidence for the benefits of vaccination whilst at the same time taking into account the different views advanced by the applicants' experts.

[92] There is a final factor of importance. In both *Four Aviation Security Service Employees* and *Yardley* I made reference to the precautionary principle and how it applied in this context. I referred to the description of that principle by the Federal Court of Ontario in *Spencer v Attorney-General of Canada* where Pentney J said:[52]

> … The precautionary principle is a foundational approach to decision-making under uncertainty, that points to the importance of acting on the best available information to protect the health of Canadians. The Order is a public health measure that was adopted based on available scientific evidence from Canada and abroad, and it gives effect to the precautionary principle in a manner that reflects the Government of Canada's overall assessment of the risks posed by the previously circulating virus and variants, and the lack of alternatives to mitigate it given the current state of knowledge of the virus.
>
> Viewed in light of the precautionary principle, the fact that the Order may not provide perfect protection is not particularly significant. The evidence shows that the challenged measures are a rational response to a real and imminent threat to public health, and any temporary suspension of them would inevitably reduce the effectiveness of this additional layer of protection. This, in turn, would have a significant – perhaps deadly – effect on the wider Canadian public, based on the experience thus far.

[93] Mr Pyke argued that *Spencer* should not be followed, identifying particular features of that decision, including that it was only at the interim relief stage. But the precautionary principle described in *Spencer* is one of general application, although

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52 *Spencer v Attorney-General of Canada* [2021] FC 361 at [113]–[114].

its nature and scope is subject to debate. It is a principle that is relevant in other areas of New Zealand law.[53] For the reasons I addressed in *Four Aviation Security Services Employees* it seems to me that it applies here.[54] Again it does not remove, or reduce the burden that is placed on the Crown, but it is a principle that applies when there is uncertainty, as is the case here.

First Disputed Issue : Vaccine effectiveness in reducing transmission

[94] Against that background I will first address the evidence relating to the effectiveness of the vaccine to limit the spread of COVID-19, including the Omicron variant.

[95] The evidence is clear that vaccination reduced both infection and onward transmission of the original versions of COVID-19, and also reduced the seriousness of illness when it occurred (and accordingly hospitalisation and death rates). That is apparent from the studies that have been referred to in evidence. That is also what I found in *Four Aviation Security Service Employees*.[55] I also accept that this was the state of the scientific evidence when the Order was implemented in October 2021.

[96] The applicants' experts make the point that unlike many vaccines the COVID-19 vaccines do not prevent a person contracting and succumbing to the illness — it is not a "sterilising" vaccine. Moreover the protection it provides wanes and only lasts for a period of months. But I accept Dr Bloomfield's evidence that the fact that it is not a "magic bullet" does not prevent it being an effective tool in limiting the spread of the virus particularly in combination with other measures.

[97] What is of significance, however, is that the Omicron variant has reduced the ability of vaccination to prevent community transmission. The applicants' experts expressed views that called into question the effectiveness of vaccination in limiting the spread of the Omicron variant in particular. By way of summary:

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53 Particularly in environment law; see *Trans-Tasman Resources Ltd v Taranaki-Whanganui Conservation Board* [2021] NZSC 127 at [107]–[113].

54 *Four Aviation Security Service Employees v Minister of COVID-19 Response*, above n 11, at [111]–[112].

55 At [109]–[110].

(a) Professor Petrovsky accepts there is some benefit to the individual from being vaccinated because of reducing the risk of serious disease, but he does not accept that vaccination can realistically reduce transmission, particularly with the Omicron variant. He emphasises that vaccination only has partial protection against transmission and only for limited periods of time. In his view being vaccinated will not reduce transmissibility over time particularly given a reproduction (or R0) rate for Omicron of between five and eight. He also sees the prospect of some increased transmission risk arising from the vaccinated having less severe symptoms, and accordingly not taking steps to avoid community interaction.

(b) Professor Bridle's evidence is to the effect that natural human immunity to COVID-19 is superior to the protections arising from vaccines. He also refers to the waning effect of the vaccine and argues that statistical analysis of countries with and without high vaccination rates does not show that higher vaccinated countries have lower COVID-19 case rates. He also expresses the view that vaccination may ultimately harm the natural responses to infection, and that it will be adverse in the longer term.

(c) Dr Cramp's views are consistent with these views, but are more wide-ranging. His evidence is striking, however, because he is the Medical Officer of Health at Waikato District Health Board. He has concerns about the safety of the Pfizer vaccine, and he significantly doubts its efficacy and has chosen not to be vaccinated himself, putting his job at risk. A key aspect of his evidence is that there is uncertainty about the safety of the vaccine, and that mandates are fundamentally inconsistent with usual medical practice and the principle of informed consent. Otherwise he argues along similar lines to Professors Petrovsky and Bridle in terms of questioning the effectiveness of the vaccine.

[98] The applicants' experts also emphasise the role of other measures such as physical distancing, facemasks, and regular testing as effective measures. I see that

the key aspect of all this evidence is that the benefit of vaccination is likely to be temporary, and that the Omicron variant will still ultimately make its way through the community in any event such that vaccination has little beneficial effect, and may in fact be harmful.

[99] Both Drs Town and Bloomfield have given evidence that vaccination may continue to limit the spread of the Omicron variant, however. These views are based on the international studies that continue to become available. Dr Bloomfield summarised the conclusions of these studies in his second affidavit sworn 1 March 2022 in the following terms:

> The vaccine efficacy is around 55% or more soon after 2 doses of Pfizer and that this wanes to levels unlikely to reduce infection risk and transmission within 5–6 months of the second dose.
>
> The vaccine efficacy is around 55% to 69% after the booster dose of Pfizer. The data also suggest while there is some waning of efficiency after the booster dose, this occurs more slowly than after the primary course, with efficiency remaining above 50% in those who had received a booster more than 10 weeks prior.
>
> …
>
> Data about the impact of the vaccine on onward transmission of Omicron is still developing, due to the time since discovering this variant and being able to observe the effects of booster dosing. As such, data are only available that assess the effect of 'all vaccines', not Pfizer alone. However, non-peer reviewed data from a small study suggests that vaccinated people infect fewer people in their household, which is a setting where many 'exposure events' are likely to occur (meaning that this setting would generally tend to reduce the observed vaccine effectiveness, and that the effect of the vaccine is likely underestimated in this study).

[100] The last paragraph referred to onward transmission, whereas the first two are referring to the efficacy of the vaccine in reducing initial infection. But reducing initial infection in itself limits the transmission of the virus in the community. A vaccinated teacher or doctor is less likely to contract COVID-19 in the first place irrespective of the limitation on his or her likelihood of spreading it to others. Dr Bloomfield also responds to the argument that the Omicron outbreak is so pervasive that vaccination can do no more than slow the infection rates down. He says that he does not accept this, but that even if that is so slowing down the spread of the virus will prevent the health system being overwhelmed.

[101] Dr Cramp explains in his affidavit that the percentages used to describe this efficacy can be misleading. If the vaccine is assessed as having 50 per cent efficacy against infection it only means that relatively less vaccinated people will be expected to be infected all other things being equal. For example, if there is a unvaccinated group that has 100 infected people within it, the expectation will be that only 50 people will be infected in an equivalent vaccinated group. But for an individual this reduction in risk might be small. If the 100 infected people represent only one per cent of a total population the reduction in individual risk is only .5 per cent. I accept this point as far as it goes, but in my view it does not go far. The Omicron variant may be much more difficult to control, and significant numbers of New Zealanders seem likely to be infected by it. I note that Professor Petrovsky is of the view that at least 50 per cent, and more likely a larger majority of the New Zealand population will become infected by COVID-19. If vaccination reduces the relative chances of infection by 50 per cent then this is a material contribution. That would be even more so if the efficacy against infection is 55–69 per cent, although as Professor Petrovsky emphasises this effectiveness may only be temporary.

[102] Dr Town stresses that evidence concerning the effectiveness of Omicron is still emerging, and it was important not to express certainty when that is not warranted. He says:

> In relation to Omicron, studies show that vaccination provides some protection against symptomatic disease, however, vaccine effectiveness is reduced compared to Delta. Rapid waning of vaccine effectiveness occurs against Omicron, but a booster dose restores protection. …

[103] Whilst I see that as broadly consistent with Dr Bloomfield's views, Dr Town's views are expressed more cautiously. Dr Town appended the most recent summaries of the international studies at the date of his affidavit, including a summary as at 3 February 2022. There are a number of studies that are referred to in this material which I accept supports the conclusions that both he and Dr Bloomfield have outlined.

[104] One of the studies referred in the evidence was subject to more attention by the expert witnesses, and submissions from the parties. In a Danish population study through to December 2021 the authors reported vaccine effectiveness against Omicron infection at 55 per cent in the first month after vaccination which declined rapidly over

a few months. Booster doses re-established effectiveness to similar levels. This was one of the studies relied on by Dr Town and is broadly consistent with Dr Bloomfield's evidence. Dr Cramp emphasised however, that this study shows that 91-150 days after vaccination the risk of infection *increased* for the vaccinated compared with the unvaccinated at greater than 50 per cent. Dr Cramp said that this demonstrated that vaccination had an adverse effect in the longer term. This is consistent with the view of Professor Petrovsky who explained that vaccination could increase the risk of infection because the vaccinated modify their behaviour believing they have protection. The authors of the study expressed the view that this data "… arguably suggests different behaviour and/or exposure patterns in the vaccinated and unvaccinated cohorts causing underestimation of the [vaccine effectiveness]. This was likely the result of Omicron spreading rapidly initially through single (super-spreading) events causing many infections among young, vaccinated individuals".[56]

[105] I accept based on this, and other evidence, that the proposition that vaccination materially limits transmission of the Omicron variant is now much more debatable. At the time when the mandate was decided upon in October 2021 the complications caused by Omicron were not apparent. I accept that the Crown rightly saw vaccination as providing significant protection against community transmission of Delta at that stage. But the question is now less certain because of the nature of the Omicron variant and the emerging information.

[106] There is a further factor of note. Schedule 3 of the Order requires the person to have had two doses of the Pfizer vaccine, with the second within 35 days of the first dose. Clause 7 of the Order was amended on 23 January 2022 so that the affected persons were also required to have received a booster dose.[57] Schedule 4 specifies that the person must receive the booster dose of the Pfizer vaccine before carrying out the work "within 183 days of being vaccinated". The requirement to be boosted only within 183 days (that is six months) of being vaccinated is very difficult to understand. The evidence is clear that the benefit that vaccination has in reducing rates of transmission wanes quickly after the first 30 days, but is restored by the booster. To

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56 Hansen C H and others "Vaccine effectiveness against SARS-CoV-2 infection with the Omicron or Delta variants following a two-dose or booster BNT162b2 or mRNA-1273 vaccination series: a Danish cohort study" (Denmark, 23 December 2021).

57 See n 17 above.

only mandate the booster within six months of being vaccinated is inconsistent with securing the benefits of vaccination imposed through a mandate. Indeed this period of time seems to me to be irrational if the whole purpose of the mandate is to ensure maximum protection against transmission. I am, to say the least, perplexed by this.

[107] For the reasons I have outlined I nevertheless find it difficult to make definitive findings on the extent to which mandatory vaccination still meaningfully reduces the spread of the Omicron variant based on the evidence and submissions I have received. It would appear that New Zealand is experiencing a wave of Omicron infection in much the same way as other countries have. But I have not been provided with evidence on the dynamics of such waves of infection, and the effects of vaccination on them. Neither do I have evidence about any secondary waves, or the risks of further variants emerging apart from Dr Bloomfield's comment that any further variants would need to be even more infectious to outcompete with Omicron.

[108] As I have explained there is a limit on the ability of the parties, or the Court to assess these issues contemporaneously. I am not able to make definitive findings on the continued effectiveness of vaccination to suppress the transmission of the Omicron variant in current circumstances. I am able to find that it did based on the evidence in existence when the mandates were put in place, but the position is now far more contestable. I accept that an arguable basis for continued effect in materially suppressing transmission may still exist. I can go no further than this given what is before me.

[109] I will address how these findings affect the Court's ultimate conclusions later below.

Second Disputed Issue : Safety of the Pfizer vaccine

[110] The expert evidence filed by the applicants also raised questions relating to the safety of the Pfizer vaccine. I agree this is also potentially relevant to the justification for the mandates.

[111] The Pfizer vaccine has been approved in New Zealand under the Medicines Act. As explained above, Ellis J considered and dismissed an application for interim

relief associated with the approval although she identified an issue with the general availability of the vaccine under a provisional consent. She concluded that interim relief should not be granted.[58] When doing so she said:[59]

> … 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.

[112] In *Four Aviation Security Service Employees* I considered an argument that mandating the Pfizer vaccine when it had only obtained provisional consent meant there had been a breach of the right not to be subjected to medical or scientific experimentation under s 10 of the Bill of Rights. When doing so I referred to the above passage indicating that I agreed with it.[60] Later in the judgment I expressed the view based on the evidence I received in that case that the Pfizer vaccine was safe and effective.[61]

[113] The applicants' experts nevertheless question the safety of the Pfizer vaccine. There are difficulties in assessing this evidence for the reasons I have already outlined. There has not been a focus on the particular points being taken by the applicants, with expert evidence directed to these particular points, and expert conferral and cross-examination directed to them. Neither were particular issues identified and explained in submissions. Unlike other aspects of the case, Drs Town and Bloomfield did engage with the evidence filed by the applicants' experts on the safety of the vaccine, although no evidence from an independent expert was filed by the Crown. I nevertheless address the disputes between the experts having regard to the way they have been presented to the Court.

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58 *Nga Kaitiaki Tuku Iho Medical Action Society Inc v Minister of Health*, above n 7.
59 At [69].
60 *Four Aviation Security Service Employees v Minister of COVID-19 Response*, above n 11, at [35]-[36].
61 At [143].

[114] I accept that a concern about the safety of the vaccine could be highly material to an assessment of whether mandating it was demonstrably justified. As I have earlier explained the right in s 11 is closely associated with the right of informed consent. For the state to pressurise particular categories of employees to vaccinate when there were safety concerns might be hard to justify.

[115] Having considered the evidence I am not satisfied that the Pfizer vaccine has unaddressed safety issues. I accept the views of the applicants' experts that there is no long-term safety data. Given the pressing need to find effective vaccines, and to deploy them once they were developed, it is inevitable that this was done without long-term data. But nothing in the materials I have been provided suggest to me that any uncertainties in the long-term are likely to give rise to the identification of unforeseen adverse effects. Dr Town refers to the considerable domestic and international work directed to ensuring that the Pfizer vaccine is safe. This includes the fact that it has been approved for use in at least 130 countries and that more than 10 billion doses have been administered worldwide. He says:

> Because of the exceptionally high level of national and international scrutiny, testing and reporting to which the Pfizer vaccine has been subject and our ongoing analysis of the available evidence, I am satisfied that the vaccine is safe. In particular, I am satisfied that the claims that receiving the vaccine is a greater health risk for any gender, ethnicity or age cohort than the health risks posed by the virus itself, are not correct. There is a small group of people for whom the vaccine does present potential health risks. It is for that reason that a procedure for granting of health-based exemptions to the mandates has been provided.

[116] The applicants' evidence includes criticisms of the extent and conditions of the trials undertaken by Pfizer when developing the vaccine. To the extent that it is possible for me to make findings about those criticisms I do not accept that they give rise to a safety concern. I am satisfied any unforeseen problems arising from this initial work, or otherwise, would have revealed themselves by now. The global pandemic, and the response to it with vaccination programmes, must be one of the most highly scrutinised medical events in human history. I am not satisfied that Dr Town's evidence on this point is wrong.

[117] This point also addresses the criticism that there is only a passive programme for assessing adverse events arising out of the administration of the vaccine. By

relying on the reporting of adverse events, rather than by actively conducting lines of enquiry it is suggested that there will be an underreporting of adverse events. For example Dr Cramp suggested that there should have been fuller investigation of reported deaths arising in the period following administration of the vaccine. I agree that a more active programme to investigate potential adverse effects would likely have been more accurate, and this could have been appropriate. But I do not accept that this demonstrates that there has been significant underreporting of adverse effects resulting in a greater level of adverse effects from that anticipated. For under reporting to have occurred in a material way it would have needed to have occurred on a worldwide basis because the vaccine is being administered on that basis. As I say, vaccination programmes have been subject to intense scrutiny. If there had been any evidence emerging of problems with the vaccination this would be known.

[118] As Dr Town accepts there are adverse side effects from the vaccine. That is apparent from Pfizer's own materials. Dr Cramp emphasised this in his evidence. He identified the adverse events that have been recorded to 20 November 2021 in New Zealand, including 92 people having anaphylaxis, 46 people who have had heart attacks, 277 people having myocarditis or pericarditis, 80 people who have had strokes, and 31 people who have had spontaneous miscarriages (amongst other adverse reactions). Individually such events can seem startling. But it must be remembered that over 96 per cent of the New Zealand population over 12 years of age have received at least one dose, and 95 per cent have received two doses. As Dr Cramp said, as at 20 November 2021 when he assessed the number of adverse events, there had been over 7.3 million doses of the Pfizer vaccine administered in New Zealand. So these events fall within the very low percentage of adverse events expected by Pfizer's data, and confirmed by worldwide experience.

[119] I should not be taken to dismiss the evidence from the applicants' experts on these issues out of hand. I accept that these are genuinely held views by well-qualified specialists in their respective areas. There was some criticism in the Crown's submissions of Dr Cramp's objectivity, but I do not accept it. He is no more or less objective than Drs Bloomfield and Town. It is just he has a different view and has concerns. He is sufficiently concerned not to yet get vaccinated himself with the potential adverse implications for him personally. But I am not satisfied from the

evidence that the adverse effects of the Pfizer vaccine are other than as assessed in the approval of the vaccine as a medicine.

Third Disputed Issue : Adverse implications of mandate

[120] In their submissions and evidence both applicants emphasised significant adverse effects arising from the vaccine mandates within each of the sectors. Such adverse implications are relevant, and go into the mix in terms of whether the public benefits derived from the mandate provide justification for the infringement of the fundamental rights involved.

[121] Much of the evidence I was referred to related to the education sector, with a number of affidavits filed by the second applicant, and submissions advanced by Ms Green by reference to particular impacts in that sector. But it is not limited to the education sector. Affidavits were filed by health professionals outlining the adverse effects of the mandate for some of those involved. That included evidence of practices such as dental practices needing to cease operation, with the considerable adverse implications for the practice and its patients.

[122] Evidence relating to the education sector was provided by Helen Hurst, the Head of Covid Response at the Ministry of Education. Based on her evidence there were approximately 72,000 teachers and day relievers, and approximately 40,000 teacher aides, administrators and other non-teaching staff in schools in 2020. A survey conducted between December 2021 and January 2022 suggests that just short of 3,000 such workers remained unvaccinated at that time. Other evidence suggested that 294 teachers/day relievers and 427 teacher aides, administrators and non-teaching staff gave "COVID" as a reason for termination of their employment. Ms Hurst said that the Ministry is unaware of any schools that have had to close down or cease operating as a result of the vaccine mandate, but that there were four schools that were required to provide online teaching for a short period of time. She emphasised, however, that the Ministry was not the employer of the workers, and that the Ministry may not have complete information on the implications that the mandate could have had.

[123] The number of education workers who were pressured into vaccination to preserve their position is not known by the Ministry. Ms Hurst's evidence suggests

that something in the order of three per cent of teachers remained unvaccinated, leading to a potential loss of employment. But Ms Green argued that the number was far higher than this, and that the true implications of the mandate were more significant, including because of the adverse implications for the teaching environment in particular schools and other education centres.

[124] Ms Green took me through a number of affidavits filed by the second applicant in that respect. I refer to some of the evidence by way of example. A teacher at a High School in Northland described the position there. Commissioners have been appointed to replace the Board at this school. She said that at her school and the wider region there were six teaching staff, including herself who at the date of her affidavit had decided not to be vaccinated. She said that in the region there were 17 vacancies advertised and that her school was in a dire position with vacancies as it stood, and that other schools were in a similar position. She also said the effect on social cohesion had been significant in the region. She used the situation at another school as an example. This school is also described in the affidavit of its proprietor. It is an integrated composite special character school. He said about 20 per cent of the teaching staff and 30 per cent of board staff had said they did not wish to be vaccinated, and if the staff had to leave the school the teaching programme would have suffered dramatically. He explained that 80 to 90 per cent of their students were Māori. He also said that the school would not want to make the parents feel alienated by their decision not to be vaccinated as this would create whakama. He said "to even ask another person (should they be a visitor for sport or music, or a parent helper) what their private health information is and then ask them to leave, should they not be vaccinated, is against the [our] tikanga of manaakitanga …". A similar situation is explained by a deputy principal of a Northland school who said there were 13 staff wishing not to be vaccinated, and that this presented a very difficult situation for the 70 per cent Māori students and families. She explained that the effects had been traumatic. It was evidence of this kind that was used in support of Ms Green's argument that the vaccine mandate involved what she said was a cultural afront.

[125] There is other evidence of a similar kind concerning other schools and education establishments throughout the country. The above are just examples. I accept that based on this evidence a significant adverse effect for schools and other

establishments potentially arose out of the mandate. And I accept that these potentially adverse implications are relevant and need to be taken into account.

[126] But as the Crown argued there are equally important countervailing considerations. The communities described in this evidence include the type of communities that are more at risk from COVID-19. That is a point not only stressed in the Crown's evidence, but it has been referred to by the Waitangi Tribunal's report into the Government's management of the COVID-19 pandemic.[62] I note that the Tribunal itself concluded that vaccines were safe and effective in responding to the threat caused by COVID-19.[63] The Tribunal also noted that Māori had been subjected to "prolonged exposure to misinformation" about vaccination.[64] It seems to me that some of the misunderstandings about COVID-19, and vaccination, were reflected in the evidence and submissions of the second applicant. And the underlying findings of the Tribunal are that the government should have recognised the features of the Māori population in order to achieve a more successful programme of vaccination amongst Māori. In my view the Tribunal's report must be treated as authoritative.

[127] An outbreak of COVID-19 in the type of communities described in the evidence could have severe adverse implications for them. The views in the Tribunal report might suggest that mandates are a blunt instrument when dealing with communities of this kind, but there is nevertheless a pressing need to seek to find measures to minimise the risk to these communities by maximising vaccination and thereby minimising the risks of transmission.

[128] I see it as significant that a number of the witnesses filing evidence on behalf of the second applicant said that they had been pressurised into becoming vaccinated. I recognise that their evidence is that they have done so notwithstanding their right to refuse to undergo a medical treatment. But this evidence also establishes that affected workers have become vaccinated as a consequence of the mandate. This confirms the benefit of the mandate in securing a more fully vaccinated education workforce, including in the more vulnerable communities.

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62 Waitangi Tribunal *Haumaru-The COVID-19 Priority Report* (WAI 2575, 2021) [preliminary version].
63 At [2.2.3].
64 At [4.4.9].

[129] Ms Green also argued for the second applicant that there was a particular issue in relation to the timing of the vaccine mandate introduced by the Order, coming as it did right at the end of the 2021 academic year when students were facing pressures such as exams. I see very little substance in this point. The timing of the measure was a consequence of the COVID-19 pandemic, and particularly the emergence of the Delta variant which rendered the elimination strategy unsustainable. The Government then introduced different measures in October 2021 to seek to control the spread of the virus within New Zealand communities. The fact that this coincided with the end of the academic year is unfortunate, but many adverse effects of the pandemic are. This is not a factor relating to the legitimacy of the measures employed that has any significance.

Conclusions

[130] Given all the above considerations, including my views on the matters that are in dispute, I come to make findings on whether the Crown has demonstrated that the vaccine mandates established by the Order are demonstrably justified in a free and democratic society.

[131] I have already found that, subject to the disputed factual matters that I have now addressed, both mandates involve a potentially justifiable limit on the s 11 right. I accept they meet standards of the kind set out by Tipping J in *R v Hansen*. That is so in the health and disability sector although there is an issue about the scope of the mandate. Similarly in the education sector a justification appears to exist albeit that the argument is less powerful than in the health and disability sector.

[132] Having now addressed the disputed matters I accept that when the challenged mandates were put into effect in October 2021 they were demonstrably justified for both sectors. At this stage the Omicron variant had not yet emerged and the measures were more directed to the Delta variant. At that stage there was clear evidence that vaccination both protected the vaccinated from more serious illness, and that it materially reduced rates of community transmission. I do not accept that there were unanticipated safety concerns, or that the adverse impacts of the mandate were more significant than the public benefits to be obtained. On that basis they were justified.

[133] Even when implemented the justification for the education mandate was less clear cut than for the health mandate, however. Moreover there could be a legitimate argument about the scope of the health mandate given that it covered particular health workers who were not dealing with vulnerable persons as patients, or with persons who were unable to make informed choices on accessing such services. But I nevertheless find that both of the mandates in their terms were demonstrably justified at the time they were implemented.

[134] But circumstances have significantly changed since the mandates were put into effect. The Omicron variant is far more transmissible, and vaccination (and therefore mandatory vaccination) is a less effective measure for controlling the spread of the virus. So, for example, ensuring all teachers are vaccinated made real sense when seeking to control the spread of the Delta variant of COVID-19. But the Omicron variant means that COVID-19 is, or will be, endemic in the community. It is spreading in a largely uncontrolled way such that the unvaccinated status of a teacher (for example) now provides relatively less meaningful protection. It may be that sufficiently equivalent protection exists by the teacher taking other steps, such as staying away if unwell, wearing a mask, maintaining social distancing, and testing. The extent of community transmission in existence may mean that comparatively little is gained by requiring educators to be vaccinated.

[135] For reasons I have already explained it may be the function of the Court to consider whether a change in circumstances means that an order that has been put into effect is no longer demonstrably justified in a free and democratic society. But there are three relevant factors that need to be considered when assessing that issue here:

(a) First is that there is an inherent limitation on the Court's ability to address matters contemporaneously. It can only address issues that have been properly advanced by fair procedures.

(b) Secondly, in this particular case there have been limitations on the evidence and submissions presented to the Court.

(c) Finally, the Act itself contemplates such changing circumstances through s 14(5) which obliges the Minister and the Director-General to keep the Order under review. That is the appropriate place where such a re-assessment should occur given the fast changing nature of the pandemic and the need to respond to it by prompt action. Here the government itself has now announced that the education sector mandate will be removed, and the scope of the health and disability sector mandate will be reviewed and potentially narrowed.

[136] Against that background the precautionary principle also remains one of key significance. I recognise the view of the applicants' experts that vaccination may make matters worse rather than better. But I am not persuaded of this. I accept that vaccination has apparent benefits in reducing transmission. I do so notwithstanding the requirement for a booster, which is critical to retain beneficial effect, has been set at a period of time that may not have a rational basis. I also accept the benefits now seem less apparent and the point may have been reached where the reduced benefits mean that the measures are no longer demonstrably justified.

[137] The Omicron variant has significantly changed the assessment, and has required the Order to be reconsidered. That has now occurred, at least in part. The education sector mandate has now been revoked, and the scope of the health and disability sector mandate is to be reviewed. So ultimately the critical issue is one of timing.

[138] Given the significant limitations I have explained I do not accept that the education mandate was not demonstrably justified at the time of trial,[65] and accordingly at any material time before it was revoked. I accept that it was justified when it was put into effect in October 2021, and that has been reviewed and then revoked as appropriate given changed circumstances. It remained a demonstrably justified measure for that period.

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[65] Or perhaps, more accurately, a point before trial when the parties had had a fair opportunity to address the issues in their evidence.

[139] The position concerning the health mandate is more complex as the Crown's stance is that this mandate will continue, but its scope will be reviewed. I accept that the mandate was demonstrably justified as at the time of trial notwithstanding a change in circumstances created by the Omicron variant. I agree that its justification is less apparent for some currently captured by the Order such as dentists or other health professionals for whom the factors in paragraph [71] are not all applicable. It may be that any justified mandate would be limited to particular health and disability sector environments such as hospitals and aged residential care facilities. But the Court is not in a position to reach a definitive finding on this given the limitations in the evidence and submissions before it.

[140] It is also appropriate to record that even a more limited health and disability sector mandate may need an assessment on whether a mandate under the Act is truly necessary given the alternative vaccination measures that would otherwise be available. Hospitals and aged care facilities, for example, are likely have very high vaccination rates in any event, and an ability to impose vaccination requirements without the need for an order under the Act. That will likely need to be considered as part of the review.

[141] Mandates under the Act should not be imposed to introduce measures that concern business as usual. The measures implemented under the Act must be considered as emergency measures only. When the Attorney-General first reported to Parliament on the compliance of the proposed Act with the Bill of Rights one of the reasons why the proposed legislation was assessed as compliant was that it did not require a person to undertake any particular ongoing form of treatment.[66] The Attorney-General's report also stated:[67]

> In our view, for a public health crisis to justify significant intrusions on protected rights and freedoms the situation must:
>
> (a) be of an exceptional and temporary nature;
>
> (b) pose an actual or imminent threat; and
>
> (c) affect all branches of the life of the community.

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66 Hon Andrew Little "Consistency with the New Zealand Bill of Rights Act 1990: COVID-19 Public Health Response Bill", above n 6, at [33].

67 At [21].

> The last two factors are taken from the decision of Lord Bingham in *A v Secretary of State for the Home Department*.[68] Although that case concerned a terrorist threat, we consider that the same criteria need to be satisfied in the case of a public health threat.

[142] Without expressly endorsing this criteria I agree with the general thrust of the point. The fact that COVID-19 continues to pose a threat justifying a notice under the Epidemic Preparedness Act 2006 may not be sufficient in itself. The kind of measures contemplated by the Order involve more immediate threats justifying an emergency response in order to justify the significant limitation of fundamental rights.

[143] Vaccine mandates, as emergency measures, need a justification of this kind. The evidence as it is emerging may suggest that a sufficient justification of this nature may no longer exist. Normal measures imposed by employers by usual requirements may be sufficient. They are also potentially more flexible, including on issues such as booster or further doses, and in relation to exemptions. But I am not in a position to conclude that this point was reached before the Prime Minister's announcement that the mandates would be removed for the education sector, and potentially narrowed for the health and disability sector. Neither am I able to conclude that any narrower mandate in the health and disability sector cannot be justified. The state of the evidence, as presented, means I do not make that finding. For these reasons I accept that the measures in the Orders remained a demonstrably justified limit on the rights in the Bill of Rights at the time of trial, and that the Order is not unlawful on this basis. The applicants' claims on this basis are accordingly dismissed.

[144] Finally, and for the avoidance of doubt, I dismiss the applicants' challenges based on unreasonableness or irrationality on the same basis. They do not meaningfully add to the challenge focussed on whether the Crown has demonstrably justified the limitation of rights.

Challenge to exemption criteria

[145] The applicants' final head of challenge is that the criteria for obtaining an exemption to the vaccination requirements established by the Order were unreasonable or irrational, or applied in an overly rigid way such that the Order should be set aside.

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[68] *A v Secretary of State for the Home Department* [2004] UKHL 56, [2005] 2 AC 68.

[146] The primary obligation in cl 7 of the Order is that an affected person not carry out certain work unless they are vaccinated. That was later amended to also require the booster. When initially enacted on 25 October 2021 cl 7A of the Order established a process for medical exemptions to be granted by suitably qualified health practitioners. That clause has since been revoked. Dr Bloomfield explains that there was a concern that a small number of medical practitioners were providing medical exemptions when they were not clinically justified. A decision was made to move to a centralised system in order to ensure consistency of decision-making, and to make sure the system was not abused.

[147] The Order was accordingly amended on 5 November to introduce cl 9B and a table specifying the categories of person who could be exempted from the vaccination requirement. The new procedure contemplated a medical practitioner or nurse practitioner applying to the Director-General for an exemption in accordance with the criteria in the table. The exemption criteria in the table were developed by the Clinical Advisory Group at the Ministry of Health chaired by Dr Town. The criteria were first gazetted on 12 November 2021 and were then reviewed. The criteria were amended on 19 January 2022.

[148] When originally established the power to grant an exemption was contained in the Order itself, utilising the power in s 12(1)(d) of the Act. This section provides that orders under s 9 could authorise the Director-General to determine that the order did not apply in particular circumstances. The position was made clearer by amendments made to the Act on 25 November 2021.[69] The amendments inserted s 5(3) of the Act which provides:

> (3) The Director-General may make a notice specifying (for the purposes of all or any legislation in, or made under, this Act)—
>
> (a) COVID-19 vaccination exemption criteria:
>
> (b) for the purposes of a COVID-19 vaccination, the required doses for each COVID-19 vaccine or combination of COVID-19 vaccines.

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69 COVID-19 Response (Vaccinations) Legislation Act 2021.

[149] Part of the applicants' challenge included an allegation that the Director-General did not have the power to issue the exemption criteria although the argument was not pressed by the applicants in their submissions. Section 5(3) of the Act makes it quite plain that he could do so. I also accept that prior to the introduction of s 5(3) it was likely within s 12(1)(d) of the Act for the Director-General to do so. There is no need to read down that provision.

[150] The real thrust of the applicants' arguments was that the exemption criteria were unreasonable, or are being applied overly rigidly or arbitrarily/unreasonably. Ms Green took me to cases of individuals who had not been granted an exemption notwithstanding their personal circumstances. Some of those who filed affidavits believe that they were harmed by the vaccine. For example, one teacher said he was harmed by his first vaccination in November 2021 and was admitted to hospital in December with pericarditis. He applied through his GP for an exemption in early December but was declined. Other witnesses describe similar adverse reactions. Yet others had concerns given their own health background. For example, one school principal has had three heart attacks and does not wish to be vaccinated. He applied for and was declined an exemption. There are other cases of this kind.

[151] I accept that these people, and others have understandable concerns about vaccination because of their own health background, or a concern that they may have had an adverse reaction to the vaccine (or some other vaccine). But the Court is not well placed in a judicial review to make decisions about individual cases, and I did not apprehend that I was being asked to do so. Rather the evidence was put forward in support of the argument that the exemption criteria themselves were unreasonable, or were being unreasonably applied.

[152] I do not accept these arguments. The respondents' evidence establishes that the exemption criteria are based on clinical grounds. If there was an additional clinical criteria that should have been included then that would need to be established by the applicants filing appropriate expert evidence about that further category. It is difficult for the Court to uphold a challenge to clinical criteria based on individual assertions about personal circumstances in affidavit evidence.

[153] I agree with the respondents that it was appropriate to assess exemptions on clinical grounds. To allow exceptions when circumstances were understandable, but not clinically indicated, would have been difficult. More generally I accept that there was a relevant concern that allowing exemptions on a basis permitted by individual health practitioners was open to abuse. It is apparent from this very challenge that there are general practitioners, and other health professionals, who are strongly opposed to vaccination. In those circumstances it was understandable that the Ministry made the decision to centralise the exemption process, and to do so only through clinically prescribed criteria. That is what the procedures followed have involved, and it is expressly authorised by the Act under s 5(3).

[154] For these reasons I dismiss the applicants' challenge that the exemption criteria are unreasonable, irrational or applied in an unreasonable, irrational or overly rigid way. I note, however, that one of the reasons why any narrower health and disability sector mandate may be more appropriately implemented under normal employment obligations rather than by orders under the Act may be precisely because of the greater flexibility that is possible in that context by comparison to the more hard edged approach mandated by orders under the Act.

Summary of the Court's conclusions

[155] For the above reasons I dismiss the applicants' claims.

[156] I accept that the right to be free to refuse medical treatment is a significant one which is based on individual autonomy. It is also reflected in the concept of informed consent that is central to the practice and ethics of medicine. But I do not accept that it is an absolute right. It is subject to reasonable limits, prescribed by law, that are demonstrably justified in a free and democratic society under s 5 of the Bill of Rights. That view is not only consistent with international authority, but is consistent with the approach that has been adopted in New Zealand in separating out the right to refuse medical treatment from other more absolute rights in the Bill of Rights.

[157] I also accept that, subject to the disputed questions raised by the applicants, justification existed in the health and disability sector, and education sector for the mandates when they were implemented in October 2021. In the health and disability

sector the close interaction between health professionals and patients, the patients potential vulnerability, the limitation on the ability of patients to make informed choices, and the need to keep public confidence in health services provided justification for the mandate. These arguments are less significant for some health professionals, such as dentists, but the potential justification nevertheless arises.

[158] I also accept that such justifications existed in the education sector. It was important for students to be able to learn in a school environment, and that environment created a potential transmission risk. In effect the community was requiring significant numbers of children to congregate with others, and with adults. There was a risk of COVID infection for the children, but more particularly a risk to the community that the children interacted with. That potentially justified a risk minimisation approach, albeit the justification is less clear cut than in the health sector.

[159] I have considered three main factual matters the applicants have contested, particularly through their expert evidence, but also their evidence more broadly given these justifications.

[160] First, it is clear that vaccination had a significant role in minimising the transmission of the virus at a time when the mandates were in place in October 2021. The emergence of the Omicron variant at the end of November calls into question the level of protection arising from the vaccine mandates, however. The evidence still suggests, on the basis of clinical studies, that vaccination has an effect in reducing transmission. But the largely uncontrolled community spread of Omicron may make any benefit from measures such as the mandatory vaccination of teachers relatively less significant and accordingly less justified. It was factors of this kind that have led the government to recently revoke the education sector mandate. Based on the evidence and argument before the Court it is not possible for me to conclude that the remaining benefits of vaccination are non-existent, or that any limited benefit means the measure was unjustified at a point of time prior to the Government's decision to revoke the mandate in the education sector, and potentially limit it in the health and disability sector.

[161] Secondly, I do not accept the applicants' expert evidence that there are unknown safety concerns relating to the Pfizer vaccine that mean that mandating it is not justified. There are known side effects from the vaccine in a limited number of cases. There is no basis to conclude the adverse effects are actually more significant. The vaccine went through a very thorough process when originally obtaining approval. Moreover the extent to which vaccination has taken place internationally would mean that any unanticipated adverse effects would have revealed themselves by now. I do not accept the applicants' arguments about safety for these reasons.

[162] Thirdly, I do not accept the applicants' argument that there have been adverse effects from the vaccine mandate for health and education professionals, and for the wider community, that mean that the mandate was and is not justified. There have plainly been adverse effects. This is particularly apparent in the education sector given the onward affect for wider communities. But some of those communities are precisely the communities that may be most at risk from COVID-19. So the adverse economic and social effects by prohibiting unvaccinated teachers from working, for example, is not out of proportion to the benefit to these communities in reducing the potential harm caused by COVID-19 itself.

[163] For these reasons I accept that the education sector mandate was, and remained justified through to when it was revoked. The position in the health and disability sector is more complicated as the Crown has advised that it intends to continue the mandate in that sector, but with a potentially narrower scope. I agree that the current scope of the Order may be too broad. But I am nevertheless satisfied that, at the point of trial, the Order as implemented remained justified. That view proceeds on the basis that there will now be a full assessment of the scope of the Order. If the Order is not reduced in scope it may become unjustified.

[164] Moreover the continuation of the health and disability sector mandate for even narrower areas such as hospital and aged residential care facilities may need to involve an assessment of whether vaccination requirements can be satisfactorily addressed by existing employment and other measures that mean that the emergency measures contemplated by the Act are not necessary.

[165] Ultimately the question concerning the justification for the COVID-19 mandates now comes down to a question of timing. Such mandates can only be justified as emergency measures. At the time they were introduced in October 2021 the Delta variant was the dominant variant. The emergence of the Omicron variant has changed the dynamics, and on 23 March 2022 the Prime Minister announced that the education mandate would be removed, and the health mandate potentially narrowed. I am not persuaded that these changes were too late, or that the mandates had become unjustified prior to that point. I accept that there remains an issue about the scope of the health and disability sector mandate and its continuation, but that will need to be addressed in light of the dynamics of the Omicron variant, and the continuing public benefit from mandatory vaccination under the Act. The Court is not in a position to conclude that any remaining mandate in the health and disability sector is unjustified, at least at the time of trial.

[166] I also conclude that the challenge to the exemption criteria should be dismissed. I am not persuaded that the criteria themselves were unduly narrow, or that they have been applied in an unlawful way. But a more flexible approach to exemptions under employment arrangements may be more appropriate for any narrower health and disability sector vaccination requirements.

[167] For these reasons the applicants' judicial review challenges are dismissed. If there is any issue in relation to costs I will receive memoranda (no more than five pages plus a schedule for each party).

Cooke J

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