IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

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

CIV-2022-485-9
[2022] NZHC 2026

UNDER	the Judicial Review Procedure Act 2016
IN THE MATTER OF	the COVID-19 Public Health Response (Protection Framework) Order 2021
BETWEEN	OREWA COMMUNITY CHURCH AND OTHERS Applicants
AND	MINISTER FOR COVID-19 RESPONSE AND THE DIRECTOR-GENERAL OF HEALTH Respondents

Continued…

Hearing: 16-17 June 2022

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Judgment: 16 August 2022

JUDGMENT OF GWYN J

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CIV-2022-485-123

UNDER	the Judicial Review Procedure Act 2016 and Part 30 of the High Court Rules 2016
IN THE MATTER OF	an application for judicial review
BETWEEN	FREE TO BE CHURCH TRUST Applicant
AND	MINISTER FOR COVID-19 RESPONSE Respondent

TABLE OF CONTENTS

Introduction

[1] This case concerns whether, as part of the New Zealand government's response to the Covid-19 pandemic, various restrictions imposed were unlawful because they limited the right of the applicants to manifest their religious beliefs.

[2] There are two claims, the first is brought by Orewa Community Church and others (Orewa); the second by the Free to Be Church Trust (FTBC). Both claims are brought against the Minister for Covid-19 Response (Minister) and the Director-General of Health (Director-General).

[3] Both applicants challenge the lawfulness of the Covid-19 Public Health Response (Protection Framework) Order 2021 (the Order). The provisions of the Order set out various ways to regulate activities and gatherings, including faith-based gatherings, at different levels of Covid-19 risk. The Order imposed limits on the size of gatherings, depending on whether attendees had Covid vaccination certificates (CVCs) or not, and depending on what level of the Covid-19 Traffic Light Framework was in place.[1] Lower limits applied where participants did not have CVCs.

[4] While there are differences between the claims by Orewa and FTBC, both say the limits placed on gatherings by the Order are in breach of their right to manifest religion under s 15 of the New Zealand Bill of Rights Act 1990 (Bill of Rights Act) and are therefore ultra vires.

Orewa

[5] The Orewa applicants comprise:

(a) Orewa Community Church, Orewa;

(b) the Al Hikmah Trust, Auckland;

(c) St Anthony's Catholic Church, Whanganui;

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1 COVID-19 Public Health Response (Protection Framework) Order 2021, cls 46 and 47.

(d) Bridges Church, Cambridge;

(e) C3 Churches, Auckland, Taupō and Christchurch;

(f) Central Worship Centre Church, Avondale;

(g) City Impact Churches;

(h) Connect Church, Paraparaumu;

(i) Curate Churches, Auckland, Tauranga, and Whakatāne;

(j) Encounter Churches, Auckland, Levin, and Bream Bay;

(k) Equippers Auckland Trust, Auckland;

(l) LifeChurches, Auckland;

(m) New Life Churches;

(n) Papatoetoe Community Church, Papatoetoe; and

(o) Reverend Johnathan Grant, the Vicar of St Paul's Symonds Street, Auckland.

[6] The Orewa applicants have presented a large number of affidavits from members of the applicant churches and mosques. In addition, Dr Matthew Flannagan, a theologian, and Professor Timothy Flanigan, a specialist in serious infectious diseases and public health, have given expert evidence for the Orewa applicants.

[7] The Orewa applicants argue that both the CVCs and the gathering limits in the Order unjustifiably limit their rights to manifest their religion. That is, all capacity restrictions imposed on faith-based gatherings under the Order were, and continue to

be, unlawful.[2] The Orewa applicants also argue that the Minister failed to appropriately take the right to manifest religion into account in introducing the restrictions in the Order.

FTBC

[8] FTBC is a trust incorporated under the Charitable Trusts Act 1957 and represents ministers and church leaders of various Christian protestant denominations. The FTBC trustees who have brought the proceeding are:

(a) Andre Bay, the pastor of Shore Baptist Church, Auckland;

(b) Jason Winslade, the pastor of Redemption Church, Christchurch;

(c) Logan Hagoort, the pastor of Covenant Presbyterian Church, Christchurch;

(d) Phil Henderson, the pastor of Onekawa Bible Church, Napier;

(e) Bruwer Vroon, the pastor of Grace Church, Gisborne;

(f) Matthew Johnston, the pastor of Riverbend Bible Church, Hastings;

(g) Nick Clevely, the pastor of Covenant Grace Baptist Church, Timaru; and

(h) Kris Baines, the pastor of Community Bible Church, Wellsford.

[9] The FTBC applicants say that the restrictions in the Order made arbitrary distinctions between faith-based gatherings and comparable situations and that the Minister did not move fast enough in removing the CVC-based limits on faith-based gatherings once the Omicron variant of Covid-19 emerged in the community. They say that, at that point, the restrictions became an unjustified limit on their right to

[2] As of 4 April 2022, CVCs are no longer part of the Order. Capacity restrictions at the Red setting remain in the Order. New Zealand is currently at the Orange setting.

manifest their religion. Alternatively, the FTBC applicants argue the Covid Protection Framework (CPF) restrictions are unreasonable. FTBC does not challenge the capacity restrictions that remain at the Red traffic light setting.

[10] The FTBC applicants also put forward a number of affidavits from members of the applicant churches. They did not file their own expert evidence but relied to some extent on Professor Flanigan's evidence.

Summary of conclusions

[11] I have determined that:

(a) The measures in the Order do limit and restrict the applicants' rights and freedoms under s 15 of the Bill of Rights Act.

(b) The measures were a justified limit on those rights and freedoms, both at introduction and after the Omicron variant was circulating in New Zealand.

(c) The Minister did not act unreasonably by making distinctions in the Order.

[12] My reasons for reaching those conclusions are set out below.

Background

[13] On 30 January 2020 the World Health Organization (WHO) declared the Covid-19 pandemic a Public Health Emergency of International Concern. Covid-19 is a disease caused by a novel coronavirus called SARS-CoV-2. As is now well-known, the first case was identified in Wuhan, China, in December 2019, but the disease soon spread all over the world.

[14] In the first phase of the Covid-19 pandemic, prior to the development of a vaccine, the New Zealand government's strategy was to eliminate Covid-19 from the

community. On 23 March 2020, the Prime Minister issued an epidemic notice[3] and on 25 March 2020, New Zealand went into its first nation-wide lockdown. The elimination strategy had a number of aspects, including border restrictions, contact tracing, regular testing of frontline workers and the Alert Level system. From March 2020 to October 2021, New Zealand moved between Alert Levels with adjustments to restrictions as required.

[15] Restrictions on gatherings were, for most of 2020 and 2021, a central part of the Alert Level system. Services provided at places of worship were classed as "gatherings" from the beginning of the Alert Level system.

[16] The Pfizer-BioNTech vaccine (the vaccine) was approved by the New Zealand Medicines and Medical Devices Safety Authority (Medsafe) in February 2021 and a rollout of the vaccine occurred across New Zealand during the course of 2021. The Pfizer vaccine has been the primary vaccine used in New Zealand. By early August 2021, Covid-19 had been eliminated within New Zealand.

[17] In August 2021 New Zealand had its first community outbreak of the Delta variant of Covid-19 and the country was placed in Alert Level 4 lockdown on 17 August 2021. Most of New Zealand returned to Alert Level 2 by 7 September 2021, but parts of Auckland, Northland and Waikato remained in the higher Alert Levels for months.

[18] On 24 September 2021 Cabinet received preliminary advice as to how proof of Covid-19 vaccination could be used to reduce the impact of Covid-19 on public health. A briefing of that date from the Department of the Prime Minister and Cabinet (DPMC) and the Ministry of Health said:

> As New Zealand's vaccination programme advances, the use of vaccination as a condition of entry to venues provides a potential additional risk mitigation measure to further reduce the risk of outbreaks…
>
> The public health benefit of using CVCs in high-risk events and venues depends on the level of vaccination coverage, if an outbreak is occurring, and the number of COVID-19 cases. CVCs could mitigate the risk of COVID-19

[3] This notice has been renewed every three months since and remains in force today.

> outbreaks in some settings and protect vulnerable populations by reducing the risk of COVID-19 spread.
>
> Secondary benefits could be to incentivise vaccination and provide reassurance to event organisers that their event is unlikely to be cancelled if there is an escalation of Alert Levels…
>
> The events and venues that are considered to be highest risk are those where there are large numbers of people, which continue for a long period of time, and where there is close interaction between attendees. The key risk factors to use when identifying high-risk events and venues include:
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> - Number of people
> - Proximity to each other / density and crowding / whether people are travelling or living together
> - Length of time together
> - The proportion of people that attend from outside the region
> - Ventilation systems at indoor venues
> - Presence of vulnerable people

[19] The advice also noted that CVCs should be considered as part of a wider suite of interventions to reduce the risk of community transmission of Covid-19, such as staying at home if sick, mandatory record-keeping, zoned areas to maintain smaller bubbles, reinforcement of hygiene messaging and mask wearing.

[20] The advice noted that proof of a negative Covid-19 test is less effective in benefitting public health than proof of full vaccination because vaccination generally provides better assurance of baseline protection. Proof of vaccination would be the stronger public health measure.

[21] Following receipt of that advice, the Minister agreed to consultation on a framework for requiring, prohibiting and enabling the use of CVCs.

[22] On 27 September 2021 the Prime Minister briefed Cabinet on a proposed strategy, which introduced the three levels of what came to be known as the Traffic Light Framework, with different settings for Red, Amber (subsequently Orange) and Green. Officials were directed to develop the preliminary framework further to add in detailed settings, based on modelling, science and public health advice.

[23] Consultation, including with places of worship, occurred on the preliminary framework which included, in regard to gatherings (whether private, church or marae) that:

(a) at Green, gatherings would have no restrictions;

(b) at Amber, gatherings would have no restrictions with a vaccination requirement or limited numbers and attendees seated and separated; and

(c) at Red, gatherings would be strictly limited.

[24] The Prime Minister reported back to Cabinet on 4 October 2021 on the Strategy for a Highly Vaccinated New Zealand. Cabinet agreed to use CVCs in some domestic settings. Officials were asked to explore a range of domestic settings where they might be used, taking into account the risk of transmission at specific events, due to the number of people in attendance and the types of activities being performed.

[25] The Strategic COVID-19 Public Health Advisory Group (SPHAG) was asked to comment on the paper considered by Cabinet on 4 October 2021. It raised concerns that the Traffic Light settings were not sufficiently restrictive.

[26] On 14 October 2021 the Minister for Covid-19 Response, Mr Chris Hipkins (the Minister), received a further joint briefing from DPMC and the Director-General updating him on progress and future work required in relation to the development of a new domestic response framework. The advice noted that:

(a) Vaccination requirements should be considered as part of a wider suite of interventions to reduce the risk of community transmission of Covid-19.

(b) Vaccination requirements could be used to reduce the risk of super-spreader events, at least until vaccination rates are well over 90 per cent across all (eligible) age and ethnic groups.

(c) There was public health benefit in people being vaccinated at all higher-risk settings.

(d) Vaccination requirements do not mitigate all risk of transmission and cannot always be considered as a substitute for other public health measures.

[27] On 18 October 2021 Cabinet decided to move from the elimination strategy to a minimisation and protection strategy, with the Covid Protection Framework as the central element. The CPF laid out response measures for what was, by then, a highly vaccinated population, without relying on lockdowns. The CPF features three levels:

(a) Green – aims to allow normal social and economic activity, while continuing to build health system capacity.

(b) Orange – aims to avoid exponential growth in cases, with moderate population-level controls.

(c) Red – aims to protect the sustainability of the health system and the health of communities through population-level controls.

[28] The CPF framework sought to leverage the protections of vaccination by providing greater freedoms to people when they were fully vaccinated. The vaccination requirements were different at each level, in response to the level of risk involved.

[29] Cabinet agreed that decisions to move between levels would be guided by thresholds for change, developed by the Ministry of Health:

(a) Green – case numbers kept low through testing, contact tracing and quarantine and hospitalisations at a manageable level.

(b) Orange – a move to Orange would occur with increasing community transmission, increasing pressure on the health system, or increasing risk to at-risk populations.

(c) Red – a shift to Red would occur when Orange is no longer containing the virus in the original outbreak areas, action is needed to protect the healthcare system, and the health of communities, or at-risk populations.

[30] On 26 October 2021 the Prime Minister reported to Cabinet on revised settings for the introduction of CVCs.

[31] The Guidelines for Places of Worship (Guidelines) were issued on 29 November 2021.

[32] On 30 November 2021 the Minister made the Order. The Order came into force on 2 December 2021.

[33] The first case of the Omicron variant of Covid-19 was detected in the community in New Zealand on 22 January 2022. On 23 January 2022, the Minister ordered that all of New Zealand be moved into the Red setting of the CPF. On that same day, Cabinet decided to introduce a three-phase system to address Omicron, which would run alongside the CPF, with a focus on testing, contact tracing and self-isolation requirements for new cases.

[34] On 25 January 2022 the Minister briefed Cabinet on updates to the Red settings of the CPF, reflecting Ministry of Health advice to him:

> Current evidence suggests Omicron has higher transmissibility, and vaccines show reduced effectiveness against the Omicron variant compared to Delta. This means that more vaccinated people are likely to become infected and that the number of COVID-19 cases occurring each day will be far greater than at any other time during the pandemic. At the initial stages of this outbreak, the overall response to Omicron will focus on 'stamping it out'. Once community case numbers increase, our focus will shift to 'managing the virus' to slow the spread, mitigate impacts on the most vulnerable and maintain essential activities and supply chains.

[35] The Minister also noted that decreasing the number and risk of exposure events was a core public health measure to manage transmission:

> Lower capacity limits in high-risk settings will help to reduce the transmission of the virus. However, there is no precise level of capacity limits for particular kinds of venues that is optimal. Rather, reducing capacity limits is a tool

> which may be used alongside other public health measures, and specific limits should be set by reference to both those other measures and the practical implications for businesses, whanau and others who will be affected.

[36] A further Public Health Risk Assessment on 2 February 2022 recommended that gathering limits at the Red setting remain unchanged at that point, but be kept under regular review as the Omicron outbreak evolved, with a view to reducing gathering limits should there be rapid and uncontrolled community transmission.

[37] During February Omicron cases in New Zealand continued to rise substantially. The Government response was to shift to Phase 2 of the Omicron response on 15 February 2022 and to Phase 3 on 24 February 2022. At that point, there were over 5,000 recorded cases each day. By 27 February 2022, there were 14,491 cases recorded, with 305 patients in hospital (including five in intensive care) and one death.

[38] From mid-February 2022 the Government was focussed on planning for its future Covid-19 response after the Omicron wave had reached its peak. Central to that was a review of the CPF.

[39] On 4 March 2022 Ministry of Health officials advised the Director-General that physical distancing and capacity limits would remain necessary during the Omicron outbreak, but once the peak was over there would be a strong case to revaluate gathering limits. The advice said it was "too early to conclude that there is an insufficient public health rationale for CVCs to be used to prevent entry to certain premises."

[40] On 21 March 2022 the Minister reported back to Cabinet on the CPF review and sought decisions from Cabinet on the post-Omicron peak Covid-19 response. The relevant Cabinet Paper noted that the elimination strategy and minimisation and protection approach had prevented the worst impacts of Covid-19. Modelling indicated that hospitalisations were likely to peak sometime in mid to late March and would decline thereafter.

[41] Cabinet was informed that CVCs would have served their purpose once the Omicron peak subsided and that the significant limit on rights that they reflected would no longer be proportionate to the public health risks in the next phase. However, the Paper advised Cabinet that CVCs remained an important part of the "toolkit" for those businesses and organisations who wished to continue using them and as part of a future response if, for example, a more severe, immunity-evading variant emerged for which there is a new, effective vaccine. The Paper also advised that, to be effective, CVCs need to be updated to reflect the roles of boosters and acquired immunity.

[42] The Director-General's initial recommendation in early April 2022 was that the Government retain CVCs until the end of August 2022. However, the Director-General's final view was that CVCs could be removed and Cabinet agreed to remove CVCs from the CPF on 4 April 2022. That decision was informed by:

(a) The Ministry of Health advice that, while two doses of the vaccine provide some reduction in Omicron transmission, it was less so than for Delta.

(b) New Zealand now had one of the highest vaccination rates in the world, with approximately 95 per cent of those aged 12 and over having had two doses of an approved vaccine (88 per cent for Māori). Unvaccinated people therefore represented a smaller transmission risk than when CVCs were introduced.

(c) The increasing level of acquired immunity from the Omicron outbreak.

(d) The fact that it would take five to six weeks to incorporate a booster into the CVC system and for the public to download their new CVC for use, by which time New Zealand would likely be well past its Omicron peak.

[43] Cabinet also decided that, without CVCs and with public health risks from the virus being lower after the peak, the CPF could be simplified as follows:

(a) At Green: no capacity limits would apply.

(b) At Orange: no capacity limits would apply, but allocated seating or one metre physical distancing would be strongly encouraged, particularly for events of 500 or more people.

(c) At Red: outdoor capacity limits would be removed. Indoor capacity limits for gatherings were increased from up to 100 people to up to 200 people, based on one metre physical distancing.

[44] On 10 June 2022 the Minister made the COVID-19 Public Health Response (COVID-19 Vaccination Certificate) Order Revocation Order 2022 revoking the COVID-19 Public Health Response (COVID-19 Vaccination Certificate) Order 2021, as well as making consequential amendments removing references to CVCs in the Order, effective 17 June 2022. The requirement to use CVCs in some settings is thus removed, but the traffic light system remains in place and the Red setting continues to provide for a limit of 200 people at indoor gatherings.

[45] That is the framework that remains in place as at the date of hearing and this judgment.

[46] On 13 April 2022 New Zealand moved to the Orange setting of the Traffic Light Framework.

Legal framework

The COVID-19 Public Health Response Act 2020

[47] The COVID-19 Public Health Response Act 2020 (COVID-19 Act) came into force on 13 May 2020.

[48] The COVID-19 Act authorises the Minister to make orders under s 11. Section 9(1) of the Act sets out the requirements for doing so.

> **9 Requirements for making COVID-19 orders under section 11**
>
> (1) The Minister may make a COVID-19 order under section 11 in accordance with the following provisions:

(a) the Minister must have had regard to advice from the Director-General about—

(i) the risks of the outbreak or spread of COVID-19; and

(ii) the nature and extent of measures (whether voluntary or enforceable) that are appropriate to address those risks; and

(b) the Minister may have had regard to any decision by the Government on the level of public health measures appropriate to respond to those risks and avoid, mitigate, or remedy the effects of the outbreak or spread of COVID-19 (which decision may have taken into account any social, economic, or other factors); and

(ba) the Minister must be satisfied that the order does not limit or is a justified limit on the rights and freedoms in the New Zealand Bill of Rights Act 1990; and

(c) the Minister—

(i) must have consulted the Prime Minister, the Minister of Justice, and the Minister of Health; and

(ii) may have consulted any other Minister that the Minister (as defined in this Act) thinks fit; and

(d) before making the order, the Minister must be satisfied that the order is appropriate to achieve the purpose of this Act.

…

[49] The Minister may, in accordance with s 9, make an order under s 11 for a number of purposes, including requiring persons to comply with any specified measures so as to contain, reduce, control, manage, or limit the risks of the outbreak or spread of Covid-19 and/or to avoid or mitigate the actual or potential adverse public health effects of the Covid-19 outbreak (whether direct or indirect).[4] The s 11 power includes the power to make orders requiring persons to permit entry to places only in compliance with the specified measures.[5]

[50] The Minister and the Director-General must keep any Covid-19 orders under review.[6] In addition, there are a number of other safeguards to ensure the Minister's powers are not misused.[7]

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4 COVID-19 Act, s 11(1)(a).

5 Section 11(1)(b)(ia). Section 11(h)-(k) affords the Minister the power to regulate how CVCs are used, including the power to require persons to permit individuals to enter a place or receive a service whether or not those individuals are vaccinated (under s 11(1)(h)).

6 Section 14(5).

7 For example, any order can be made only where there is an epidemic notice, a state of emergency, or a notice in the Gazette from the Prime Minister authorising the making of an order (s 8) (an epidemic notice is currently in force); orders must be gazetted and publicly notified 48 hours

[51] Before making an order the Minister must be satisfied that the order does not limit or is a justified limit on the rights and freedoms in the Bill of Rights Act.[8]

COVID-19 Public Health Response (Protection Framework) Order 2021

[52] On 30 November 2021, the Minister signed the COVID-19 Public Health Response (Protection Framework) Order 2021 (the Order). The Order came into effect on 2 December 2021.

[53] The purpose of the Order is "to prevent, and limit the risk of, the outbreak or spread of COVID-19 and to otherwise support the purposes of the Act".[9]

[54] Part 2 of the Order contains a range of public health measures which only apply once they are specified in a COVID-19 response schedule that applies to a particular region.[10] The effect of this is that an activity is permitted unless an active schedule expressly limits it.

[55] On 2 December 2021, when the Order took effect, there were two active schedules:

(a) The Red schedule was active for Northland, Auckland, Taupō and Rotorua Lakes District, Kawerau, Whakatāne, Ōpōtiki Districts, Gisborne District, Wairoa District, Rangitīkei District, Whanganui and Ruapehu Districts; and

(b) The Orange schedule was active for the rest of New Zealand.

[56] From 23 January 2022 the Red schedule was active for all of New Zealand, with the whole country moving to the Orange setting on 13 April 2022.

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before they come into force, unless the order is required to come into force urgently to prevent or contain the outbreak or spread of Covid-19 (s 14(2) and (3)); orders are automatically revoked, unless approved by the House within a specified time (s 16); Parliament expressly removed any doubt that the COVID-19 Act would limit access to the Court to challenge the lawfulness of any order (s 13(3)); and the COVID-19 Act itself must be continued by resolution of the House every 90 days (s 3).

8 Section 9(1)(ba).

9 Order, above n 1, cl 3.

10 Clauses 16 and 17.

[57] The Order, as introduced, defined gathering:[11]

> **13 Meaning of gathering**
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> In this order, gathering—
>
> (a) means people who are intermingling in a group but excludes people who remain at least 2 metres away from each other, so far as is reasonably practicable; and
>
> (b) includes—
>
> (i) a gathering to undertake voluntary or not-for-profit sporting, recreational, social, or cultural activities:
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> (ii) a gathering to undertake community club activities (except activities that occur at the same time and place as services provided under a club licence under section 21 of the Sale and Supply of Alcohol Act 2012):
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> (iii) a faith-based gathering:
>
> (iv) a funeral or tangihanga:
>
> (v) a gathering held in a defined space or premises of a workplace (other than a vehicle in use as part of a public transport service) that have been hired for the exclusive use of the gathering by a person (other than the person who manages or controls the defined space or premises); but
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> (c) excludes a gathering for the purpose of a business or service at—
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> (i) office workplaces; and
>
> (ii) ordinary operations at retail; and
>
> (iii) gyms; and
>
> (iv) hearings at courts and tribunals; and
>
> (v) education entities at normal operations.

[58] The definition encompassed private gatherings and specifically included faith-based gatherings.

[59] In the Red setting[12] there are to be no gatherings unless permitted,[13] and a permitted gathering is one where:

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11 Clause 13.
12 Schedule 7.
13 Clause 42.

(a) If it is a gathering of "CVC compliant" people, it is subject to a fixed number of 100 and a one-metre physical distancing rule;[14]

(b) If it is not a gathering of all "CVC compliant" people, it is subject to a fixed number of 25 and a one-metre physical distancing rule.[15]

[60] In the Orange setting,[16] there are to be no gatherings unless permitted,[17] and a permitted gathering is one where:

(a) If it is a gathering of "CVC compliant" people, there is no fixed number limit;[18]

(b) If it is not a gathering of all "CVC compliant" people, it is subject to a fixed number of 50 and a one-metre physical distancing rule.[19]

[61] In the Green setting,[20] there are to be no gatherings unless permitted,[21] and a permitted gathering is one where:

(a) If it is a gathering of "CVC compliant" people, there is no fixed number limit;[22]

(b) If it is not a gathering of all "CVC compliant" people, it is subject to a fixed number of 100 and a one-metre physical distancing rule.[23]

[62] A CVC means a COVID-19 vaccination certificate issued under cls 8 or 9 of the Order.[24] "CVC compliant" was defined in the Order:[25]

6 When person is CVC compliant

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14 Clause 46.
15 Clause 47.
16 Schedule 6.
17 Clause 42.
18 Clause 46.
19 Clause 47.
20 Schedule 5.
21 Clause 42.
22 Clause 46.
23 Clause 47.
24 COVID-19 Public Health Response (COVID-19 Vaccination Certificate) Order 2021, cls 8 or 9.
25 Order, above n 1, cl 6.

(1) In this order, a person is CVC compliant if the person—

(a) holds a valid CVC issued to that person; or

(b) is under the age of 12 years and 3 months; or

(c) is a student participating in an extra-curricular or a curricular activity.

(2) A person who is required under an applicable COVID-19 provision to ensure or verify that a person (person A) is CVC compliant satisfies that requirement if the person reasonably considers that person A is,—

(a) in relation to subclause (1)(b), under the age of 12 years and 3 months; or

(b) in relation to subclause (1)(c), a student participating in an extra-curricular or a curricular activity.

[63] The government issued Guidelines for Places of Worship on 29 November 2021[26] which explained the application of the Order in the context of places of worship. Under the CPF restrictions, a religious group could choose to:

(a) require CVCs for all services and offer larger services;

(b) require CVCs for no services and offer smaller services;

(c) offer both services operating with CVCs and services operating without CVCs (as long as spaces were cleaned between groups, there was no intermingling of the two groups, spaces used were ventilated, and those involved were clear on the distinction); or

(d) if an organisation had multiple defined spaces in a venue, operate multiple activities at once, with an activity requiring a CVC in one space and an activity not requiring a CVC in another space (provided there was no intermingling between groups).

[64] As under the Alert Level system, online services remained an available option for religious groups to reach the members of their congregations.

[65] On 4 April 2022, CVCs were removed from the CPF.

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[26] The Guidelines were subsequently amended on 4 April 2022.

The relevant right – s 15 Bill of Rights Act

[66] The Bill of Rights Act affirms the fundamental freedoms and rights it sets out.[27] Those rights and freedoms "may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society".[28]

[67] The Bill of Rights Act applies to acts of the legislature, executive and judiciary and by any person or body in the performance of any public function, power, or duty conferred or imposed on them in, by or pursuant to law. This means that the Bill of Rights applies to the Order. The COVID-19 Act explicitly recognises that, in making an order under s 11, the Minister must be satisfied that the order does not limit or is a justified limit on the rights and freedoms in the Bill of Rights Act.[29]

[68] To the extent the provisions of the Order impose limits on the right to manifest one's religion, they must meet the "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society" requirement.[30]

[69] The right the applicants say is engaged in this case is the right to manifest their religion:[31]

> **15 Manifestation of religion and belief**
>
> Every person has the right to manifest that person's religion or belief in worship, observance, practice, or teaching, either individually or in community with others, and either in public or in private.

[70] The right to religious freedom is directly protected by ss 13 and 15 of the Bill of Rights Act.[32] In this case, neither set of applicants contends that the right in s 13 – the freedom of thought, conscience, and religion – has been limited.

[71] The rights to freedom of religion and manifestation of that religion are also protected under art 18(1) of the International Covenant on Civil and Political Rights

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27 New Zealand Bill of Rights Act 1990, s 2.
28 Section 5.
29 Section 9(1)(ba) of the COVID-19 Act, above n 4.
30 Bill of Rights Act, above n 27, s 5.
31 Section 15.
32 Sections 19 (Freedom from discrimination) and 20 (Rights of minorities) may also be relevant in some situations.

(ICCPR)[33] and art 9(1) of the European Convention on Human Rights (ECHR).[34] Article 18.3 ICCPR and art 9(2) ECHR explicitly state that the freedom to manifest one's religious beliefs can be limited in the interest of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

[72] While s 15 of the Bill of Rights Act does not contain an explicit limitation in the terms of arts 9(2) and 18.3, the Bill of Rights Act affirms New Zealand's commitment to the ICCPR and those provisions are relevant when considering justified limits to s 15.

[73] To date, there is little New Zealand case law on the rights to freedom of thought, conscience, religion and belief and to manifest religion or belief.

[74] In *New Zealand Health Professionals Alliance Inc v Attorney-General*,[35] the plaintiffs (health practitioners) challenged s 14 of the Contraception, Sterilisation and Abortion Act 1977 (CSAA). The provisions require the health professional to tell the patient of their conscientious objection to providing assistance to a patient in regard to abortion services or related advice. In addition, using the list maintained under s 18 of the CSAA, the health professional must identify the closest provider of abortion services to that person's practice, and tell the patient how to access the contact details of that provider. The applicants in that case said the s 14 requirement infringed their rights under ss 13 and 15 of the Bill of Rights Act. Justice Ellis found that the s 13 right to freedom of thought, conscience and religion was not engaged and that the refusal to provide the information required by s 14 did not constitute manifesting the claimants' beliefs in observance or practice, as required by s 15.

[75] The Court went on to find that, even if s 15 did protect the applicants' freedom conscientiously to refuse to comply with s 14 of the CSAA, s 14 did not interfere with that freedom.

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33 International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976).

34 Convention for the Protection of Human Rights and Fundamental Freedoms 213 UNTS 221 (opened for signature 4 November 1950, entered into force 3 September 1953).

35 *New Zealand Health Professionals Alliance Inc v Attorney-General* [2021] NZHC 2510.

[76] In *Yardley v Minister for Workplace Relations and Safety*, Cooke J considered an application for judicial review brought by Police and Defence Force workers who did not wish to receive the Covid-19 vaccination and faced termination of their employment if they did not do so.[36] The applicants alleged that the requirement to be vaccinated placed unjustified limits on a number of their rights protected by the Bill of Rights Act, including the s 15 right to manifest religion or belief. Justice Cooke accepted the applicants' submission that an obligation to receive the vaccine which a person objects to because it has been tested on cells derived from a human foetus, potentially an aborted foetus, does involve a limitation on the manifestation of a religious belief in the "observance, practice, or teaching" of religion as contemplated by s 15:[37] "It is grounded in a core principle of the particular Christian religion and the objection to abortion." A justified limits analysis was therefore required under s 5. However, Cooke J was not satisfied of the applicants' broader claims that requiring vaccination is inconsistent with the manifestation of religion or belief arising from the concept of individual bodily integrity, personal autonomy or similar Christian views.

Are the applicants' beliefs such that their manifestation is protected by s 15?

[77] If sincerity of belief is demonstrated in relation to a practice that has a nexus with religion, it should trigger the protection of the right to freedom to manifest religion.[38]

[78] The existence and genuineness of the applicants' beliefs is not in issue in these proceedings. While some aspects of those beliefs vary as between the two groups of applicants, in general terms the relevant belief is that the physical gathering together of members of a congregation for worship is a matter of religious obligation. The expert evidence for the Orewa applicants from Dr Matthew Flannagan, emphasises the importance to Christians of assembling in community. His evidence is that Christians, including the Orewa applicant churches, believe they are commanded to assemble together, as a community, to engage in mutual teaching, exhortation, corporate

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36 *Yardley v Minister for Workplace Relations and Safety* [2022] NZHC 291 at [47]-[52].
37 At [49].
38 *Syndicat Northcrest v Amselem* 2004 SCC 47, [2004] 2 SCR 551 at [56]-[57] and [69].

worship and participation in the sacraments with one another. The Christian Orewa applicants believe this to be a duty commanded by God.

[79] The Orewa applicants say that the Order prohibited the Church and every individual in the Church from assembling in community with each other as their faith compels them. All options in the Guidelines required segregation or exclusion in some form. The Orewa Christian applicants say that it is not sufficient that the Church was able to serve its community individually, at different times and in different places. That does not amount to manifestation of their religion in community with others, in accordance with their s 15 right.

[80] Dr Flannagan also gives evidence that, in Christian theology, the practice of excluding people from the communal fellowship and worship of the Church is excommunication. In his view, the effect of the Order was to require excommunication, which is a serious infringement on the separation of Church and State.

[81] For the Muslim Orewa applicants, Imam Youssef's evidence explained that, in Islam, mosques are places where Muslims gather together. Devout Muslims are expected to attend five daily prayers at the mosque, each conducted within a specific window of time, and each Friday there is a midday congregational prayer service. For many mosques, including the applicant mosques, running segregated prayers and services is logistically impossible given the time-windows within which each prayer meeting and service must be conducted, the size of the mosque leadership teams and the fact landlords were given the power to choose to impose an exclusion policy on religious tenants.[39] Imam Youssef's evidence is that the obligation to take part in the Friday congregational prayer cannot be undertaken at home.

[82] The witnesses for the FTBC applicants describe three interrelated religious beliefs and practices they say are affected by the Order:

(a) Gathering together for worship as one family is an essential element of their faith.

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[39] A restriction imposed by private landlords is not part of the Court's consideration in this case.

(b) They are prohibited by their faith from making non-biblical distinctions between members of the Church.

(c) Certain religious practices can only be undertaken in the presence of the whole congregation.

[83] As to the first, the FTBC applicants believe that Church members must be free to gather together every Sunday as one family. They are commanded to do so by the Bible and to not do so is sin. The applicants believe that their Sunday worship cannot be conducted remotely. They point to *Philip v Scottish Ministers,* where the Court accepted that "the essential physical element of these aspects of their faith is absent from virtual, internet events".[40]

[84] In relation to the second, the FTBC applicants believe they are not permitted to treat their members differently. The Church is one, entire body and the congregants must gather together as one people. Their faith prohibits segregation and they are not to discriminate. They see the use of different services for vaccinated and unvaccinated members as a direct violation of that core tenet of their religion.

[85] Third, the FTBC applicants say there are certain religious practices that require the presence of the whole congregation – the sacraments of communion and baptism are to be received physically, in the presence of the whole, physically gathered Church. Practices such as communion may only be carried out when the body is gathered together.

[86] The FTBC applicants say that the effect of the Order has been to prevent, for the period 2 December 2021 to 4 April 2022, a significant number of members of each congregation from practising their faith, from fulfilling their duty to God, from being together with their Church family to pray, sing, have fellowship and observe the sacraments. In addition, the effect of the Order in limiting the number of people who can attend worship has been to prevent altogether those religious practices that require the whole Church to be gathered.

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[40] *Philip v Scottish Ministers* [2021] CSOH 32 (Outer House) at [5], [62] and [95].

[87] The FTBC witnesses gave evidence that the ramifications of those limits have been spiritually profoundly damaging.

[88] The respondents acknowledge the sincerity and importance of the applicants' beliefs. Professor Paul Trebilco, a New Testament theology expert, provided expert evidence for the respondents. He does not dispute that the applicants' views are genuinely held, acknowledging that:

> … within the Christian Churches of Aotearoa New Zealand, there are a range of different interpretations of the matters discussed below, including the most sincerely held views of Dr Flannagan and the Free to Be Church Trustees.

[89] However, Professor Trebilco provides a contrary theological position to Dr Flannagan's expert evidence and the fact evidence of the FTBC deponents, on whether Christians are biblically required to gather together, in person, as a whole Church without distinction. Professor Trebilco also takes issue with Dr Flannagan's evidence about excommunication. He says:

> … the unvaccinated are not actually being 'removed' or 'excommunicated' from any congregation by CVCs. Rather, the number of other believers who are part of a particular congregation with whom they can interact is being limited to 25 or 50. They are still part of the congregation, albeit not able to interact with all other members for a time.

[90] Professor Trebilco goes on to say that in the New Testament, the Church has full say over who is part of a Church and who is not. The State cannot "excommunicate" someone from Church; the State is not saying unvaccinated congregants are not part of a particular church. It is simply saying that such congregants must meet in a group of maximum size, for a period of time.

[91] The FTBC applicants say Professor Trebilco's evidence is misconceived because it challenges the "correctness" or "validity" of their religious beliefs. They say they are not required to establish that the observance of a religious practice or belief in question is a mandatory doctrine of faith, or is perceived by the applicants as being mandatory,[41] or that their belief is an objective or universally-recognised religious principle.

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[41] *Syndicat Northquest v Amselem*, above n 38, at [47]: "an inquiry into the mandatory nature of an alleged religious practice is not only inappropriate, it is plagued with difficulties."

[92] They rely on *Amselem,* where the majority of the Supreme Court of Canada said:[42]

> Claimants seeking to invoke freedom of religion should not need to prove the objective validity of their beliefs in that their beliefs are objectively recognized as valid by other members of the same religion, nor is such an inquiry appropriate for courts to make.
>
> A person must show sincerity of belief and not that a particular belief is "valid".
>
> A court is in no position to question the validity of a religious belief… it is not the role of this Court to decide what any particular religion believes.

[93] Similarly, in *Yardley v Minister for Workplace Relations and Safety,* the Court said:[43]

> … the fact that others observing the same religion do not agree with that stance does not mean that the stance does not involve the observance of a religious belief.

Preliminary questions

Deference

[94] The respondents say the Court should afford the Minister a substantial margin of appreciation where, as here, he made an Order regulating activities with the benefit of substantial scientific expert advice, and having regard to the impact on the rights of affected communities.

[95] The FTBC applicants, on the other hand, advocate for the Court's "expansive supervision". They say that ultimately, whether the measures in question were demonstrably justified is a question of law for the Court to decide and, accordingly, there can be no question of deferring to the views of the Executive.[44]

[96] A margin of appreciation, or "deference", generally signifies that the Court will show some restraint when scrutinising the Executive's policy choices.

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42 At [43]-[44].
43 *Yardley v Minister for Workplace Relations and Safety*, above n 36, at [47] and [49].
44 *Four Aviation Security Service Employees v Minister of Covid-19 Response* [2021] NZHC 3012 at [80] and [82].

[97] The role of the Court in this case is to decide whether the restrictions in the Order are a demonstrably justified limitation on the applicants' rights under s 5 of the Bill of Rights Act. It is a matter of law. But, while the Court should not abdicate this role even in exceptional circumstances, the oversight role should be conducted carefully where, as here, the expert advice was a critical factor in the adoption of the CVC-related restrictions and the evidence before the Court is also largely expert evidence.

[98] The degree of deference to be afforded is related to the appropriate approach to the evidence. Where it is established or admitted that the relevant right is in fact limited, the burden then falls on the Crown to put forward evidence that the limitation is demonstrably justified. If the applicant then wishes to argue that what the Crown's evidence establishes is factually wrong, it has the burden to persuade the Court of this.[45]

[99] Dr Ashley Bloomfield, the Director-General of Health and Chief Executive of the Ministry of Health, and Dr Ian Town, the Chief Science Advisor at the Ministry of Health, have given evidence in this case and the underlying information to which they refer, forms the evidential basis for the respondents' argument that the Order is demonstrably justified. As I will come to, while Dr Bloomfield was the principal public face of the advice to the government, he and Dr Town in turn relied on a multi-layered system of information and advice, across a broad range of disciplines and expertise.

[100] The respondents have also filed expert theological evidence from Professor Trebilco.

[101] The Orewa applicants rely on expert theological evidence from Dr Flannagan and expert medical evidence from Professor Flanigan to argue that the Crown's evidence is wrong. Professor Flanigan is a Professor of Medicine at Brown University, Providence, Rhode Island, in the United States. He specialises in serious infectious diseases and public health. Dr Flannagan is a theologian, moral philosopher and teacher from Rodney, New Zealand. The FTBC applicants have not filed any expert

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[45] At [86].

evidence to contest the respondents' evidence but do rely, to some extent, on Professor Flanigan's evidence.

[102] The approach I adopt is to consider the expert views of Dr Bloomfield and Dr Town and the underlying material to which they refer, testing or challenging their views against the expert opinions put forward by Professor Flanigan,[46] noting that none of the evidence was tested by cross-examination. Ultimately, the Court has to determine the legal question of whether the measures were demonstrably justified against that evidential background.

[103] As the Court of Queen's Bench of Manitoba said in *Gateway Bible Baptist Church,*[47] it is not an abdication of the Court's responsibility to afford an appropriate measure of deference to the technical expertise of those advising the Minister, in recognition of the expertise of those specialist positions, together with the sudden emergence of Covid-19 as a novel and deadly disease:[48]

> … where a sufficient evidentiary foundation has been provided in a case like the present, the determination of whether any limits on rights are constitutionally defensible is a determination that should be guided not only by the rigours of the existing legal tests, but as well, by a requisite judicial humility that comes from acknowledging that courts do not have the specialized expertise to casually second guess the decisions of public health officials, which decisions are otherwise supported in the evidence.

[104] The relevance of the evidence must be tested by reference to what precisely is in issue in this proceeding. The applicants have challenged some only of the restrictions imposed during the course of the pandemic. The timeframe is relevant, too. The Covid-19 pandemic was and is fluid, evolving and threatening. The situation at the start of the pandemic in March 2020 was considerably different from the position in January 2022, when the Omicron variant was first identified in the community.

[105] I conclude that it is appropriate to give some weight to the Minister's judgement to impose restrictions on a temporary basis, in a rapidly evolving

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46 See, for example, *Four Aviation Security Service Employees v Minister of Covid-19 Response*, above n 44, at [88].

47 *Gateway Bible Baptist Church* [2021] MBQB 219 at [283].

48 At [292].

emergency, informed by expert advice involving predictive assessments of risk,[49] and where the "costs of failure" would have serious consequences for the entire community.

[106] As the Ontario Superior Court of Justice put it in *Ontario v Trinity Bible Chapel*, a case about the constitutional validity of religious gathering restrictions imposed in the context of Covid-19:[50]

> This case calls for even greater deference to government decision making. Public officials were faced with an unprecedented public health emergency that foretold of serious illness and death. Ontario was called upon to protect public health, while respecting a host of other interests and considerations. Restrictive measures aimed at curbing transmission of the virus would necessarily impact on social, commercial, and religious activities. The task at hand called for a careful balancing of competing considerations, informed by an evolving body of medical and scientific opinion.
>
> …
>
> It is frankly difficult to imagine a more compelling and challenging equation… This mix of conflicting interests and perspectives, centred on a tangible threat to public health, is a textbook recipe for deferential review.

[107] Having said that, it is important to note that this judgment is not a validation or a second guessing of the government's policy choices and the adequacy or efficacy of its public health measures put in place to contain Covid-19.[51] The Court's focus is on the legality of the specific portions of the Order in question.

The precautionary principle

[108] There is a further, overlapping consideration – whether the precautionary principle is relevant, given the subject matter of the measures in the Order that are challenged.

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49 *R (Lord Carlile of Berriew and Ors) v Secretary of State for the Home Department* [2014] UKSC 60, [2014] 3 WLR 1404 at [32] (per Lord Sumption), [67]-[68], [72] (per Lord Neuberger), [98] (per Baroness Hale).

50 *Ontario v Trinity Bible Chapel* [2022] ONSC 1344 at [126]-[127].

51 *Gateway Bible Baptist Church v Manitoba*, above n 47, at [20].

[109] The precautionary principle can be summed up in the phrase "reasonable action to reduce risk should not await scientific certainty".[52]

[110] One of the principal justifications for the precautionary approach is the health risk to the wider public. As the Federal Court of Ontario said in *Spencer v Attorney-General of Canada,* in relation to restricting entry into Canada in the context of the Covid-19 pandemic:[53]

> … 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.

[111] The Order in question in this case was promulgated and justified on a public health need to suppress the spread of the Covid-19 virus and minimise its impact. The evidence for the respondents is that the government's health response to Covid-19 followed the precautionary principle. The respondents say that, in the context of measures taken for public health purposes, the Court should recognise the application of that principle.

[112] The FTBC applicants say that a broad interpretation of the precautionary principle would run counter to the requirement for the Court to apply a higher level of scrutiny in this case. To the extent the principle is applicable at all, it should be interpreted and applied narrowly. Counsel refers to the report of the Canadian SARS Commission[54] in support of a submission that, applied to this case, the precautionary

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52 Archie Campbell *The SARS Commission Final Report, Spring of Fear* (December 2006) at 8; and Katie Webber "The Precautionary Principle and Judicial Decision Making in the COVID-19 Pandemic*"* (2022) 29 AJ Admin L 43 at 44 and footnote 9.

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

54 *The SARS Commission Final Report, Spring of Fear*, above n 52, at 8.

principle meant that the Minister should have acted to reduce or remove the relevant restrictions when it first became apparent that the vaccine had reduced effectiveness against Omicron.

[113] There is an overlap between the concept of deference and the precautionary principle. Recognising the precautionary principle inevitably serves to increase the margin of appreciation afforded to the government when the Court comes to consider whether the restrictions in question were the least impairing, effective option.

[114] I acknowledge that the Court must be careful to distinguish between the role of the precautionary principle in guiding executive action, and the role of the courts in vigorously assessing government action for legality.[55] But, having said that, the relevance of the precautionary principle has been recognised in other New Zealand decisions in the Covid-19 context[56] and I accept that it is appropriate to recognise the operation of the principle in the decision-making that led to the Order. What that means is that, in the absence of full scientific evidence about Covid-19, the Minister was entitled to take a cautious approach in considering whether or not to impose, reduce or remove restrictions. That approach, rather than the approach advocated by the FTBC applicants, is consistent with the approach of the SARS Commission:[57]

> The importance of the precautionary principle that reasonable efforts to reduce risk need not await scientific proof was demonstrated over and over during SARS… We should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty.

[115] The Commission endorsed the precautionary approach of, for example, the Vancouver General Hospital which, when dealing with SARS, an undiagnosed respiratory illness, automatically went to the highest level of precautions for its health workers and then scaled down as the situation was clarified.[58]

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55 Webber, above n 52, at 43 and footnote 3.

56 *Grounded Kiwis Group Incorporated v Minister of Health* [2022] NZHC 832 at [174]; *Yardley v Minister for Workplace Relations and* Safety, above n 36, at [64] and [94]; *Four Aviation Security Service Employees v Minister of Covid-19 Response* above n 44, at [110]-[111].

57 *The SARS Commission Final Report, Spring of Fear*, above n 52, at 12.

58 At 13 and 25.

Approach to the Bill of Rights Act analysis

[116] The decisive question in both applications before the Court is whether the limitation of fundamental rights is demonstrably justified in a free and democratic society given the public interest sought to be advanced by the Order.

[117] Section 5 of the Bill of Rights Act provides:

> **5 Justified limitations**
>
> Subject to section 4, the rights and freedoms contained in this Bill of Rights may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

[118] The parties accept that the appropriate approach in considering this question is as set out by the Supreme Court in *Hansen v R*.[59] The Crown must show that any limiting measure:

(a) is prescribed by law;

(b) serves a sufficiently important objective or purpose to warrant limiting the protected right or freedom;

(c) the means chosen to achieve the objective must be proportionate to the importance of the objective. This has several elements:

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

(ii) minimal impairment – does the limiting measure impair the right or freedom no more than is reasonably necessary to achieve that purpose?

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[59] *Hansen v R* [2007] NZSC 7, [2007] 3 NZLR 1. The Court adapted the approach of the Canadian Supreme Court in *R v Oakes* [1986] 1 SCR 103.

(iii) proportional effect – the benefits achieved by the measure must not be outweighed by the significance of the limitation of the right.

[119] This is not a rigid test. As Cooke J noted in *NZDSOS v Minister for Covid-19 Response*,[60] rather, it is a framework for assessing whether the measure is demonstrably justified in a free and democratic society. Many of the questions shade into one another.

Prescribed by law; restrictions amount to a limitation

[120] There is no dispute that the restrictions challenged by the applicants are contained in the Order and are clearly prescribed by law. The respondents also accept that the CVC-related restriction did limit the applicants' right to manifest their religion.

Do the limits serve a sufficiently important purpose?

[121] The limit on the applicants' s 15 rights must serve a sufficiently important purpose, warranting the overriding of those rights.

[122] As discussed above, the purpose is set out in the Order itself. Clause 3 of the Order provides:

> **3 Purpose**
>
> The purpose of this order is to prevent, and limit the risk of, the outbreak or spread of COVID-19 and to otherwise support the purposes of the Act.

[123] Clause 3 of the Order, in turn, refers to the purposes of the COVID-19 Act, in s 4:

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

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60 *NZDSOS v Minister for Covid-19 Response* [2022] NZHC 716, at [68].

(b) avoids, mitigates, or remedies the actual or potential adverse effects of the COVID-19 outbreak (whether direct or indirect); and

(c) is co-ordinated, orderly, and proportionate; and

(ca) allows social, economic, and other factors to be taken into account where it is relevant to do so; and

(cb) is economically sustainable and allows for the recovery of MIQF costs; and

(d) has enforceable measures, in addition to the relevant voluntary measures and public health and other guidance that also support that response.

[124] The Orewa applicants accept that the sufficiently important purpose test is met. The FTBC applicants originally pleaded that the limiting measures do not serve a sufficiently important purpose to justify curtailment of the s 15 right, but by the time of the hearing no longer challenged that point.

[125] Nevertheless, for the sake of completeness, I consider the stated purpose of the restrictions. The CPF was developed in the context of a Delta outbreak in the community. The purpose of the CPF was to minimise its spread, to protect the vulnerable and to avoid the health system being overwhelmed. The principal rationale for the introduction of CVCs and related gathering limits in the CPF was the advice from the Director-General that, because of the effectiveness of the vaccine in limiting the risk of infection, transmission and hospitalisation with the virus, the use of CVCs would mitigate the risk of Covid-19 outbreaks and protect vulnerable populations by reducing the risk of Covid-19 spread. An incidental benefit was the possibility that the use of CVCs could help to boost vaccination rates. Gathering limits self-evidently limit the ability of the virus to spread in the community.

[126] These purposes were sufficiently important to justify some curtailment of the right to manifest religion.

The applicants' challenges

[127] The two applicant groups advanced somewhat different grounds in support of their submissions that the Minister could not have been satisfied that the Order was a justified limit on the right to manifest their religion and belief.

[128] The Orewa applicants challenge all the capacity restrictions (CVCs and gathering limits) in the Order as introduced.

[129] The FTBC applicants also challenge the restrictions in the Order as introduced, but primarily focus on the CVC-based restrictions once Omicron entered the New Zealand community.

CVC-related restrictions as introduced

[130] As discussed above,[61] when the Order was introduced it provided that the maximum capacity limit for gatherings, which included faith-based gatherings, without using CVCs was 25 at Red, 50 at Orange and 100 at Green. Using CVCs, gatherings were limited to a maximum of 100 at Red, with no limits at Orange and Green.

[131] The Orewa applicants challenge the restrictions under two heads. First, they say that, as introduced, the Order imposed limitations that were an unjustified limit on their s 15 rights (and continue to be so because of the gathering restriction that remains in the Order – at Red, a limit of 200 people at indoor gatherings) (the Bill of Rights claim).

[132] Second, they say that the Minister failed to understand the nature of the s 15 right. This second aspect is framed as the Minister misdirecting himself and/or erring in law (the error of law claim).

[133] The two claims are brought as separate causes of action, but there is a degree of overlap in the evidence and analysis relating to each.

[134] While it is not framed in quite this way, the essence of the Orewa applicants' Bill of Rights claim is that the restrictions were not rationally connected with their purpose and/or limited their s 15 rights more than was reasonably necessary to achieve their purpose.

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61 At [59] to [61].

Rational connection

[135] The first limb under the proportionality test is whether the limiting measure is rationally connected with its purpose. In order to establish a rational connection between the limiting measure and its purpose, it is necessary only to show that there is a "causal connection between the infringement and the benefits sought 'on the basis of reason or logic'".[62] It must be shown that it is "reasonable to suppose" the limiting measure will achieve its purpose.[63]

The scientific evidence

[136] Throughout the course of the Covid-19 pandemic, the New Zealand government has received scientific advice from a range of expert advisors and bodies. The nature and extent of that expertise is covered in the evidence of Dr Bloomfield and Dr Town.

[137] Dr Ashley Bloomfield was at all relevant times the Director-General of Health and the Chief Executive of the Ministry of Health. Dr Bloomfield is a specialist in public health medicine.

[138] Dr Bloomfield discusses the effects of Covid-19 from a public health perspective. He notes that, while most who contract Covid-19 will recover fully over time, many suffer from ongoing and long-lasting health effects. A proportion of those who contract the virus will require hospitalisation, including treatment from a ventilator and/or in an intensive care unit (ICU), which is a finite resource to treat those who suffer serious health effects from a range of medical conditions or injuries.

[139] The disease has the most severe effects on vulnerable members of the community such as the elderly and those with other health problems or co-morbidities. People with health conditions which make them vulnerable to severe effects of Covid-19 will often be classed as disabled. The virus has had a disproportionate impact on Māori and Pasifika communities.

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62 *Carter v Canada (Attorney-General)* 2015 SCC 5, [2015] 1 SCR 331 at [99] citing *RJR-MacDonald Inc v Canada (Attorney General)* [1995] 3 SCR 199 at [153].

63 *Alberta v Hutterian Brethren of Wilson Colony* 2009 SCC 37, [2009] 2 SCR 567 at [48].

[140] Modelling papers sought by the Ministry of Health showed that unchecked community transmission of Covid-19 would quickly overwhelm the health system and New Zealand would be faced with a large number of deaths.

[141] Dr Bloomfield's evidence also covers New Zealand's experience to date with the Omicron variant, which is discussed below in the context of the FTBC claim.

[142] Dr Ian Town is the Chief Science Advisor at the Ministry of Health. His speciality is in evaluating scientific evidence and helping ensure that credible science is at the core of decision-making. Dr Town chairs the COVID-19 Technical Advisory Group (TAG) and the COVID-19 Vaccine Technical Advisory Group (CV-TAG) at the Ministry of Health. Both TAG and CV-TAG include a number of immunologists, infectious disease specialists, as well as scientists from other disciplines.

[143] Dr Town is also a member of several other advisory groups within the Ministry of Health, including the COVID-19 Testing Technical Advisory Group, the COVID-19 Therapeutics Technical Advisory Group and the COVID-19 Clinical Oversight Group. Dr Town notes that these groups comprise external medical and scientific experts who scrutinise and distil the available evidence and provide advice to the Director-General.

[144] Dr Town's work is supported by scientists within the Ministry of Health's Scientific and Technical Advisory Team, which includes experienced immunologists and epidemiologists. Much of the advice provided by Dr Town in relation to transmission of Covid-19 and vaccination has been provided in his capacity as the Chair of TAG and CV-TAG. Dr Town says that this ensures that a range of expert opinion and experience is brought to bear on the issues of minimising transmission and on the safety and effectiveness of the vaccine. This stream of advice is distinct from, but complements and informs, the wider public health advice provided by the Director-General and the Director of Public Health. Specifically, Dr Town provided advice to Dr Bloomfield about the benefits and risks of the Pfizer vaccine which, in turn, informed the broader public health advice provided by Dr Bloomfield to the Government.

[145] A further layer of independent advice is provided with a COVID-19 Independent Continuous Review, Improvement and Advice Group (CICRIAG) and the Strategic COVID-19 Public Health Advisory Group (SPHAG) whose membership includes senior scientists in relevant disciplines established to provide the Government with independent expert advice. Both of those groups provide advice directly to Ministers rather than to the Ministry of Health.

[146] The Scientific and Technical Advisory team at the Ministry of Health monitors communications from WHO and other international medical bodies, as well as from the relevant scientific institutions of other governments, concerning vaccines, and provides CV-TAG with updates on relevant information for its discussions and recommendations. Examples of such international bodies include the Australian Technical Advisory Group on Immunisation, the United Kingdom Health Security Agency, the United States Centre for Disease Control (CDC) and the European Centre for Disease Prevention & Control.

[147] Two aspects of the evidence are essential to an analysis of the claims: the nature of the Covid-19 virus and how the vaccine works against it, and the risk-assessment of faith-based gatherings.

Covid-19

[148] The nature of the Covid-19 virus is explained in detail in Dr Town's evidence and, to a lesser extent in the evidence of Professor Flanigan for the Orewa applicants. Where there is a difference in their evidence, I set that out.

[149] SARS-CoV-2 is a respiratory pathogen. Transmission is through airborne droplets containing virus exhaled by an infectious individual. Transmission can occur without symptoms, such as sneezing and coughing and can occur through breathing, talking, singing or laughing. These droplets vary in size and the amount of virus they contain. Larger droplets fall to the ground soon after being exhaled, under the influence of gravity, whereas smaller droplets may remain suspended in air for a considerable period of time. That means that, while transmission risk is greatest when in close proximity to an infected person for an extended period of time, especially

indoors, infection can also occur after brief contact or from movement through the same space without contact.

[150] Dr Town's evidence is that the risk of transmission varies with different respiratory activities. Quiet breathing is associated with the lowest rate of transmission. Loud vocalising, in particular singing, is associated with much higher rates of transmission and of transmission to individuals much further away, due to airborne transmission of virus through aerosols.

[151] Prevention of transmission is achieved by either decreasing the risk of an infectious individual exhaling the virus in the presence of susceptible contacts, or by increasing the protection of individuals from being infected. Dr Town's view is that the former is the most effective mechanism to prevent transmission and includes prevention of infection of individuals by vaccination (decreasing the number of cases), gathering limits (decreasing the number of exposure events), and separation of cases and contacts (staying at home if sick). However, while transmission risk can be reduced by a range of public health measures, the risk cannot be entirely eliminated.

[152] Dr Town comments on Professor Flanigan's evidence and notes that he does not discuss the role of airborne transmission in any detail. Professor Flanigan implies it is safe to inhale a small number of viral particles (or virions) as this will not result in infection. Dr Town responds that, while this may be technically correct, in practice, it is impossible to estimate or implement. While there is a minimum infective dose, it is not possible to control how many viral particles are being expelled. Allowing people to inhale a "safe" dose of virions cannot be implemented as a means to reduce other control measures. Every case must be considered to be infectious during their infection and even a relatively small dose of virus, substantially less than the 1000 virions quoted by Professor Flanigan, may cause infection. This was confirmed in the first SARS-CoV-2 Human Challenge Trial (a trial in which humans were deliberately infected under controlled conditions in order to better study the disease's course).[64]

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64 Ben Killingley and others "Safety, tolerability and viral kinetics during SARS-CoV-2 human challenge in young adults" (2022) Nature Medicine 1031.

Asymptomatic and pre-symptomatic transmission

[153] Professor Flanigan suggests that individuals who are asymptomatic are less likely to transmit Covid-19 to others. Dr Town discusses that proposition in his detailed evidence about asymptomatic and pre-symptomatic transmission.

[154] Asymptomatic transmission refers to transmission from those who are infected but never show symptoms. Pre-symptomatic transmission refers to transmission from those who are early in infection, before the onset of symptoms.

[155] Pre-symptomatic transmission is well-established and is likely to be a significant cause of spread of the virus. Pre-symptomatic individuals are highly infectious. People can transmit the virus up to two days before they have symptoms.

[156] Asymptomatic transmission has been established, but Dr Town's evidence is that measuring the extent can be challenging and disagreement exists about the proportion of asymptomatic infections. Studies strongly suggest that Omicron has a much higher rate of asymptomatic carriage than other variants of concern, and the resulting high prevalence of asymptomatic infection is likely a major factor in the rapid spread of the variant globally.

[157] Dr Town's view is that the term "asymptomatic" should really only be applied to a person who never develops symptoms during their illness. All individuals with SARS-CoV-2 infection will be asymptomatic initially and after they recover, but may be highly symptomatic between.

[158] The difference in infectiousness of asymptomatic individuals compared to symptomatic individuals at any stage of the pandemic is unclear. Importantly, the symptomatic status is not the only variable which influences infectiousness, with substantial variation in viral load both among those who are symptomatic and among those who are asymptomatic. The Human Challenge Trial did not identify a difference in infectious viral load between symptomatic and asymptomatic individuals. Asymptomatic individuals are much less likely to be aware of their infection, seek testing or even test positive with some testing methods, and will therefore not isolate or take other precautions.

Effectiveness of the Pfizer vaccine

[159] The primary rationale for the CVC-related restrictions was the Director-General's advice that, because of the effectiveness of the vaccine, the use of CVCs would mitigate the risk of spread of the virus.

[160] Dr Town's evidence explains the three ways in which the vaccine is effective. The vaccine is able to:

(a) prevent infection;

(b) prevent severe illness and, at worst, death (referred to as the ability of the vaccine to prevent 'hospitalisation'); and

(c) prevent onward transmission from those who do become infected.

[161] The relationship between these three benefits of vaccination is at the heart of its overall effectiveness. As Dr Town explains, by reducing infections among those who have received vaccinations, the vaccine also reduces transmission (self-evidently, the uninfected will not transmit) and hospitalisations (the uninfected will not suffer severe illness). When considering the impact of the vaccine in reducing community spread and severe illness it is necessary to take into account its effect in reducing infection, before also taking into account its effect in reducing onwards transmission and hospitalisation among those who, despite being vaccinated, have become infected.

[162] Dr Town gave evidence about the effectiveness of the vaccine (vaccine effectiveness or VE) in relation to each of the Delta and Omicron variants of Covid-19.

[163] In relation to Delta:

(a) The vaccine is 79-93 per cent effective at preventing Delta infection during the first one to two months after receiving the second dose of the vaccine (including both symptomatic and asymptomatic infections).

The vaccine is 53-75 per cent effective at preventing infection more than three to four months after receiving the second dose.

(b) In relation to symptomatic infection, in the first one to two weeks immediately after the second dose, the vaccine is 92-93 per cent effective at preventing symptomatic Delta. More than three to four months after the second dose, the vaccine is 56-78 per cent effective at preventing symptomatic Delta infection.

(c) While vaccine effectiveness wanes over time, protection against severe disease remains high for at least five to six months.

[164] The effectiveness of two doses of the vaccine in preventing hospitalisation and death from Delta has been shown to be about 99.7 per cent. The effectiveness of two doses of the vaccine against death is 98 per cent at two to nine weeks after vaccination and 90 per cent at 20 or more weeks after vaccination.

[165] The vaccine reduces transmission of the Delta variant by approximately 30-50 per cent. As Dr Town notes, that reduction in transmission is in addition to individual protection against infection. This means that vaccination significantly reduces the chance of becoming infected and substantially decreases the likelihood of transmitting the virus if a vaccinated person does become infected.

[166] A booster dose of the Pfizer vaccine restores waning antibodies to levels that are similar to immediately after the primary course.

[167] Dr Town's evidence as to VE in relation to the Omicron variant is discussed at [244]-[250] below.

[168] Professor Flanigan's initial evidence did not address the effectiveness of the vaccine. In his evidence in reply, he said that the protection offered by the vaccine in relation to transmission is minimal and short-lived and therefore clinically insignificant. He does not address the three-fold impact of vaccination set out in Dr Town's evidence. As I will come to, although the FTBC applicants did not present

any expert evidence on this point, their submission that, once Omicron was in the community, there was no rational connection between the purpose of the Order and the CVC-related restrictions, was said to be based on the respondents' scientific evidence about the effectiveness of the vaccine.

Risk assessment of faith-based gatherings

[169] Both the Orewa and FTBC applicants assert that the restrictions as introduced were not rationally connected to their purpose, in part because of disparate treatment of similar activities.

[170] The first aspect of that challenge relates to the risk assessment of faith-based gatherings. The respondents' assessment at the relevant times was that faith-based gatherings are high-risk. It was primarily on this basis that faith-based gatherings were included in the definition of "gatherings" in the Order and subject to the CVC and capacity restrictions accordingly.

[171] The Orewa applicants submit that the right to manifest religion is an important one and that the restrictions are disproportionate, because faith-based gatherings are not high-risk settings when public health measures other than CVCs and gathering limits are imposed.

[172] As Dr Town's evidence notes, SARS-CoV-2 is transmitted through airborne droplets exhaled by an infectious individual. Singing is associated with particularly high rates of transmission. Transmission risk is greatest when an infected person is in close proximity for an extended period of time with another person, but infection can also occur after brief contact, or from movement through the same space without contact.

[173] Dr Town's evidence relating to pre-symptomatic transmission and asymptomatic transmission is relevant here. As he notes, it is impossible to identify individuals who are likely to transmit Covid-19 based on symptoms alone. Transmission can occur before an infected person becomes symptomatic and some infected people never develop symptoms. This does not mean that they are not

infectious – to the contrary, pre-symptomatic transmission is likely to be a significant cause of spread of Covid-19.

[174] Gathering limits aim to prevent super-spreading events. Both Dr Town and Dr Bloomfield gave evidence that super-spreading events have played a significant role in the spread of the virus in New Zealand. For example, the Omicron outbreak was initially fuelled by two main events, the SoundSplash festival and a large wedding.

[175] Gatherings that have the highest risk are those where there are large numbers of people, which continue for a long period of time, and where there is close interaction between attendees. Key risk factors include the number of people, their proximity, the length of time they are together, people attending from outside the region, ventilation and presence of vulnerable people.

[176] The evidence from both Dr Town and Dr Bloomfield is that faith-based gatherings are high-risk settings. Activities commonly occurring in faith-based gatherings such as singing, close personal contact by hand shaking, hugging and laying on of hands, administering and receiving communion, and sharing food and drink, are high risk activities and increase the likelihood of a super-spreading event. In addition, faith-based gatherings are very likely to have vulnerable people in attendance, including older people and Māori and Pasifika communities, who are at risk of severe outcomes from Covid-19.

[177] Both Dr Town and Dr Bloomfield gave as an example the August 2021 Delta outbreak where a South Auckland church was at the centre of the largest cluster. This was an example of the high-risk nature of faith-based gatherings. They also refer to a large cluster related to an outbreak at the Shincheonji Church in South Korea, at the start of the pandemic, that resulted in over five thousand cases. The applicants disputed the similarity and relevance of the South Korean example.

[178] The data from the Delta outbreak from early August until 11 October 2021 was analysed by Ministry of Health officials, with a view to determining the settings with the highest secondary attack rate (SAR). The SAR is the percentage of contacts of an index case that become a secondary case. Dr Town's evidence is that it can be a more

useful measure of transmission risk than the reproduction number, which is heavily dependent on the number of contacts.

[179] The first Delta SAR Analysis,[65] which detailed 1,051 secondary cases among the 41,440 contacts identified, found that households gave rise to the majority of secondary cases and have the highest SAR, with 45.6 per cent. The next highest SAR was for private gatherings, with a SAR of 10.4 per cent. The significance of that data is disputed by Professor Flanigan, on the basis that it only evidences 72 secondary cases arising from private gatherings, with no distinction made between faith-based gatherings and others.

[180] Dr Town's response is that this misunderstands the nature of super-spreading events and the risk they pose. As he explained, super-spreading events occur when an individual, or a small number of individuals, cause a substantial number of secondary cases, with the size of the cluster amplifying through successive chains of transmission. Individuals at a super-spreading event who contract the virus will go on to pass it on to family members and others, seeding the virus throughout the community. Dr Town provides an analysis of genomes sequenced in the period from 4 August 2021 and broadly representative of the proportion of the cases arising from different clusters in the Delta outbreak. While faith-based gatherings were not captured as a discrete variable in the dataset in Delta Outbreak SAR Analysis, the cases arising from the South Auckland church cluster are graphically represented.

[181] Professor Flanigan disputes the relevance of the Delta Outbreak SAR Analysis on the basis that general public health measures such as masking and physical distancing were not in place at that stage (in Alert Level 1), so the data does not reflect the impact of such measures on transmission. However the respondents note that no such restrictions were in place across the board at Alert Level 1 and, prior to discovery of Delta in the community, social and other activities were taking place without restriction. In that context, the fact that the super-spreading event resulting in the spread of Delta throughout the community occurred at a faith-based gathering illustrates the high-risk nature of faith-based gatherings, compared to other activities.

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[65] There were two Delta Outbreak SAR Analyses carried out by the Ministry of Health, dated 19 October 2021 and 10 March 2022.

[182] Dr Town says that the high-risk nature of faith-based gatherings was also confirmed by an analysis of gathering-related SARs from 20 January to 1 February 2022.[66] This analysis found that places of worship had the second highest SAR at 8.6 per cent (after "Other organised events" at 10.4 per cent).

[183] Professor Flanigan disputes the validity of this data too, on the basis that by this point Omicron was dominant in the community, that it was a small sample set and that the core public health measures such as those he proposed were not in place at that time.

[184] However, the respondents note:

(a) Omicron was first discovered in the community on 22 January 2022 and, for a period, overlapped with Delta, before Omicron became dominant. Whether or not Omicron was dominant for part of the period is irrelevant as the data illustrates the SAR of gatherings (and therefore comparable risk levels) in different settings.

(b) Thousands of data points were analysed and the data clearly showed that faith-based gatherings (at 8.6 per cent SAR) were the second highest risk setting after other organised events (at 10.4 per cent SAR) and both were higher risk than the other settings analysed (bars, gyms and restaurants, which are recognised as being areas of increased transmission risk).

(c) Consistent public health messaging and the Guidelines for Places of Worship were in place at the time of the outbreak and encouraged the core public health measures that Professor Flanigan refers to, in the CDC Guidelines and the Thomistic Institute Guidelines – most significantly, wearing masks, physical distancing and hand hygiene. Despite these public health measures being in place (although not mandated), places of worship were shown to have a SAR of 8.6 per cent.

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66 As shown in the Ministry of Health's second Delta Outbreak SAR Analysis of 10 March 2022.

[185] I am satisfied there was a sufficient evidential basis to conclude that faith-based gatherings were high risk.

[186] The Orewa applicants also submit that the Minister imposed restrictions on their rights as a means to encourage vaccination. I find that is clear from advice received by the Minister from DPMC and Ministry of Health officials that the primary aim in imposing the CVC-related restrictions was to minimise the spread of Covid-19. Incentivising vaccination against Covid-19 was viewed as a secondary benefit of CVCs.

Comparison with schools

[187] As well as challenging the risk assessment of faith-based gatherings per se, the Orewa applicants also submit that there was not a proper basis to treat faith-based gatherings differently from schools. The Orewa applicants also say that the differential treatment of faith-based gatherings and schools shows that the Minister did not properly understand and have regard to the right to manifest religion and/ or assessed it as less important than the right to education, which is also a right protected under the Bill of Rights.

[188] The definition of "gathering" in the Order excluded "a gathering for the purpose of a business or service at education entities at normal operations".[67] Schools were therefore not subject to the restrictions by way of limits on number and use of CVCs.

[189] In addition to his expert evidence in relation to theological matters, Dr Flannagan also gave anecdotal evidence of his experience as a religious education teacher. His evidence seeks to challenge the effect of the Order in relation to schools, compared to Sunday School services. As Dr Flannagan has not sought to qualify himself as an expert in relation to public health or education generally, I do not consider that evidence.

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[67] Order, above n 1, cl 13(c)(v).

[190] The Minister's evidence is that the decision to prioritise the opening of schools and not to use CVCs in schools was based on the importance of education to children from a developmental perspective, the importance of the right to education under national and international law, and the potential impact (including health impact) of long-term remote learning on children. The vaccination requirements should not restrict children and young people's access to learning, or parents' and caregivers' ability to support their children in their learning. The Government was aware of the long-term impacts of entrenching existing inequities and social exclusion in an education context. Although the risk assessment for schools was lower than for faith-based gatherings, the decision in relation to schools was not based on an assessment of the comparative risk of those settings.

[191] Dr Bloomfield's evidence too was that non-attendance at school can be detrimental to a child's educational and social development and wellbeing which can have long term consequences. Those risks are exacerbated in socio-economically deprived communities where schools may be the only contact children have with state authorities. Educational settings evidently cover a large proportion of the population. For those reasons, Dr Bloomfield says, the risk/benefit balance in educational settings is different than in other settings.

[192] The Minister also says that, while places of worship had alternative options for holding their services (smaller services without CVCs, CVC and non-CVC services at different times or, depending on venue, at the same time, as well as online), those choices were not available for schools. Schools operate five days a week for full days. Classroom capacity and staffing limitations mean it would not have been possible to offer different classes to those with and without CVCs. All students' education would have suffered.

[193] In any event, Dr Town disputes Professor Flanigan's evidence that the public health risks posed by schools and faith-based gatherings are equivalent. In the first Delta Outbreak SAR Analysis, the SAR of education was 0.1%, compared to a SAR of 10.4% for private gatherings.

[194] Professor Flanigan queries the Analysis, based on sample size, the effect of the Alert Levels in place at the time of the study (August-October 2021) and the fact that public health measures were in place in schools during part of the study period.

[195] In response, Dr Town notes that during this period Alert Level restrictions in New Zealand applied across all settings so would not be expected to have an impact on the SAR analysis. This analysis of thousands of data points, including 11,798 contacts in education settings, represented the actual breakdown of secondary cases in a New Zealand outbreak, at a time when all relevant cases were being identified and all contacts traced. While public health restrictions such as masking and distancing imposed once schools reopened at lower Alert Levels could be expected to have some impact, they would not be expected to result in a 100-fold decrease in transmission risk.

[196] The risks of infection and serious illness also differed as between faith-based gatherings and schools. The evidence from both Dr Town and Dr Bloomfield is that, while there is some risk of severe illness for children infected with Covid-19, particularly those who are immuno-compromised, in general, children's symptoms will be mild. In addition, all adults involved in the provision of education (teachers and parent helpers) were, during the relevant period, subject to the vaccine mandate and therefore had a base level of protection from, and a reduced likelihood of transmission of, Covid-19. In contrast, faith-based gatherings are more likely to have a higher proportion of vulnerable people in attendance, particularly elderly members of the community, who are at a disproportionate risk of severe outcomes from Covid-19.

[197] I am satisfied on the evidence that there was a proper basis to treat schools and faith-based gatherings differently.

Other activities and businesses

[198] Both the Orewa and FTBC applicants challenge what they say is the disparate treatment under the Order of houses of worship and secular activities and says the distinction is arbitrary as there is very little difference between those activities. Professor Flanigan's evidence addresses this point.

[199] The Orewa applicants rely on *Tandon v Newsom,* where the US Supreme Court granted an injunction against limits imposed by the Governor of California on religious gatherings in homes, to three households.[68]

> It is no answer that a State treats some comparable secular businesses or other activities as poorly as or even less favorably than the religious exercise at issue… whether two activities are comparable for purposes of the Free Exercise Clause must be judged against the asserted government interest that justifies the regulation at issue. Comparability is concerned with the risks various activities pose, not the reasons why people gather.

[200] The majority went onto say:[69]

> California treats some comparable secular activities more favorably than at-home religious exercise, permitting hair salons, retail stores, personal care services, movie theaters, private suites at sporting events and concerts, and indoor restaurants to bring together more than three households at a time.

[201] I did not find this decision useful. As Justice Kagan, for the minority, noted, the First Amendment requires that a State treat religious conduct as well as the State treats comparable secular conduct. Here, the State had adopted a blanket restriction on at-home gatherings of all kinds, religious and secular alike.[70]

> California need not, as the *per curiam* insists, treat at-home religious gatherings the same as hardware stores and hair salons – and thus unlike at-home secular gatherings, the obvious comparator here. … And even supposing a court should cast so expansive a comparative net, the *per curiam's* analysis of this case defies the factual record. According to the *per curiam,* "the Ninth Circuit did not conclude that" activities like frequenting stores or salons "pose a lesser risk of transmission' than applicants' at-home religious activities… But Judges Milan Smith and Bade explained for the court that those activities do pose lesser risks for at least three reasons… These are not the mere musings of two appellate judges: The district court found each of these facts based on the uncontested testimony of California's public-health experts… No doubt this evidence is inconvenient for the *per curiam's* preferred result. But the Court has no warrant to ignore the record in a case that (on its own view…) turns on risk assessments.

[202] The respondents say that some of those other, secular activities were treated differently because of the assessed degree of risk of the activity. Others were not based on an assessment of risk – for example, life-preserving services. So, supermarkets,

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68 *Tandon v Newsom* 593 US (2021), per Justice Kavanaugh for the majority, at 593.
69 At 3.
70 At 1.

pharmacies, petrol stations, health services and emergency accommodation were not permitted to restrict access by the use of CVCs.

[203] The decision not to impose restrictions on plane travel, rail, interisland ferries and other public transport was based on an assessment of the risk involved in those services. Dr Town disagrees with Professor Flanigan's evidence, and says that supermarkets, health services and transport do not pose a similar degree of risk to a high-risk gathering, such as a faith-based gathering. Dr Town notes that these settings are seldom sites of widespread transmission and do not give rise to the risk of super-spreader events. This is supported by the Delta Outbreak SAR Analysis of 19 October 2021. The SARs of both public transport and retail settings (including supermarkets) were negligible. The SAR of healthcare settings was 0.2 per cent.

[204] Retail was also assessed as a lower risk than faith-based gatherings. Under the CPF, the operators of private retail businesses and workplaces had the option of choosing whether to require CVCs as a condition of entry. Workplaces did not pose the same risk as a high-risk setting such as faith-based gatherings: in the Delta Outbreak SAR Analysis of 19 October 2021, the SAR in workplaces was 0.6 per cent. Nor does retail usually involve the congregation of large numbers of people in one place, so therefore does not pose the same transmission risk. The SAR in food, alcohol, service station and retail settings (which included all shopping-related settings such as supermarkets, trade stores and smaller outlets such as fashion retail and dairies) was negligible in the Delta Outbreak SAR Analysis.

[205] Airline travel was included in the public transport setting in the Delta Outbreak SAR Analysis. No secondary cases were connected to public transport.

[206] I am satisfied that the restrictions in the Order, as they applied to faith-based gatherings, were not arbitrary and were rationally connected to their purpose, satisfying the first limb under the proportionality test.

Less impairing alternatives

[207] The second limb of the proportionality test requires the Court to determine whether "Parliament might have sufficiently achieved its objective by another method

involving less cost to the [right]" and whether the limit imposed "is no greater than is reasonably necessary to achieve Parliament's objective".[71]

[208] The Orewa applicants submit that the CVC-related restrictions were not the least restrictive means of preventing the transmission of Covid-19 in the context of faith-based gatherings.

[209] They put forward a number of alternatives to the CVC-related restrictions which they say would be less limiting of their rights and freedoms, but equally effective.

[210] The FTBC applicants also rely on the Orewa evidence to make the same submission.

Masking, social distancing, good hygiene practices (the "three Ws")

[211] Professor Flanigan explained that in 2021 he led a team of experts in the United States who developed the guidelines for the Thomistic Institute's United States Conference of Catholics to help them remain safely open to all during the Covid-19 pandemic. The Thomistic Guidelines relied on the "three Ws" – watch your distance, wear a mask and wash your hands. Professor Flanigan's evidence was that (as at February 2022 when he swore his affidavit), there had been no clusters of cases of Covid-19 being contracted at any Catholic church service implementing the Thomistic Institute Guidelines.

[212] Professor Flanigan also refers to the CDC guidelines, *Considerations for Communities of Faith*, to help faith communities safely keep houses of worship open, "while still working to prevent the spread of Covid-19".[72]

[213] Professor Flanigan's evidence is that houses of worship can safely open while protecting against the spread of Covid-19, without imposing capacity limits, if the house of worship implements what he calls the three most effective behavioural tools

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71 *Hansen v R*, above n 59, at [126].

72 Centre for Disease Control "Considerations for Communities of Faith" (19 February 2021) CDC <www.cdc.gov>.

in combatting Covid-19: social distance, facial coverings, and hand hygiene, and has policies in place to encourage sick, potentially exposed, and at-risk individuals to stay home. He says, in having regard to those precautions, allowing a house of worship to open without set capacity limitations "should be considered reasonably safe".

[214] Dr Bloomfield emphasises that consistent public health messaging and the Guidelines for Places of Worship were in place at the time of the outbreak and encouraged the core public health measures that Professor Flanigan refers to, most significantly wearing masks, physical distancing and hand hygiene. Despite these public health measures being in place (although not mandated; nor were they mandated under the CDC Guidelines) places of worship were shown to have a SAR of 8.6 per cent.

[215] Dr Bloomfield's evidence is that:

> Measures such as masking, good personal hygiene and physical distancing all had, and continue to have, a significant part to play in achieving the public health objective of minimising the spread of the virus, and protecting the public. I do not, however, consider that such measures would have been adequate *alternatives* to the restrictions in the CPF.

Size of venue / social distancing/ventilation

[216] In Professor Flanigan's opinion, any limits on numbers for faith-based gatherings should be based solely on the size of the particular building and the ability to provide for adequate social distancing. He says this is particularly true for a country with a very highly vaccinated population.

[217] Dr Town notes three main drawbacks to the proposal to allow a certain number of individuals based on the size of the venue:

(a) In many social settings, individuals are mobile and do not maintain physical distancing, but gather in groups and move from group to group, or are in close contact during entry and exit from the venue.

(b) Gatherings of larger numbers of individuals are more likely to include multiple infectious individuals, which increases the risk spread.

(c) For a space to have reduced risk of aerosol spread, the ventilation and duration of exposure are critical factors. A poorly ventilated space,

> even if it is relatively large, poses a greater risk of transmission of Covid-19 than a small space with good ventilation.

[218] Dr Bloomfield's evidence is that there is no "bright line test" for an optimal capacity limit. Imposing density limits in relation to individual venues is not considered an appropriate approach, in circumstances where action is needed to protect the healthcare system and/or the health of communities and at-risk populations. Imposing fixed capacity limits is considered the more clear, easy to apply, and effective approach in achieving the aim of minimising the spread of Covid-19 and protecting the most vulnerable.

[219] Nor, in Dr Bloomfield's view, is it possible to take into account the ventilation capabilities of the individual venues when imposing generally applicable public health measures: "A key tenet of the CPF is its simplicity and consistently across settings."

PCR / RAT testing, prior infection

[220] The applicants suggest that regular testing of congregants, by way of PCR tests or RATs and proof of prior infection, combined with masking, physical distancing, hand sanitising and other measures, could have been used as a practical alternative to the CVC-related restrictions.

[221] Dr Bloomfield's advice to the Minister was that he had considered the possibility of using proof of a negative Covid-19 test as an alternative to proof of vaccination but ultimately advised that proof of a negative test would be less effective in benefitting public health than proof of full vaccination, as vaccination generally provides better assurance of baseline protection. Proof of vaccination would be the stronger public health measure.

[222] Nor would the use of RATs or PCRs have addressed the risk to the unvaccinated individuals themselves and the related health system burden. An unvaccinated individual is at higher risk of contracting Covid-19 in a high-risk setting, and at higher risk of hospitalisation if they contract the virus. Restricting an unvaccinated person's access to a high-risk setting protects the individual, while

limiting the number of unvaccinated people contracting the infection helps to reduce the pressure on the health system.

[223] Dr Bloomfield also notes that PCR tests are time and resource intensive and capacity to carry out the testing is limited. Following the introduction of the Omicron variant into the community, pooled sampling was no longer possible.[73] PCR testing is better focused on those who are at risk of more severe outcomes, those who present to hospital with Covid-19 related complications, people in high-risk settings such as aged residential care.

[224] The respondent's evidence also addressed the limitations of RATs, noting there are questions about their sensitivity in relation to asymptomatic or pre-symptomatic cases. That is of particular concern when the aim of the restrictions is to reduce the possibility of super-spreader events. They were therefore not considered suitable as an alternative to CVCs.

[225] At the time of making his affidavit in early May 2022, Dr Bloomfield noted that until recently the availability of RATs in New Zealand was limited and first supplies were targeted to healthcare workers and other critical workers.

[226] His evidence is that RATs continue to not be an acceptable alternative to gathering limits, given their lack of sensitivity combined with the need to control the risk of super-spreader events. They are not a suitable alternative means to control the transmission risk of large gatherings at the Red setting of the CPF.

Discussion

[227] In assessing the alternative measures proposed by the applicants, the key question is whether one or a combination of those measures would have the same effect as the CVC-related restrictions, but be less likely to be inconsistent with the applicants' s 15 rights.

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[73] Pooled sampling involved PCR samples from multiple people being tested in one group. That enabled health authorities to increase the number of tests conducted in a given period up to 10-fold.

[228] The appellate courts have adopted a "range of reasonable alternatives" test to determine this question.[74]

[229] The Court of Appeal in *Ministry of Health v Atkinson* said:[75]

> [151] There is no dispute as to the relevant principles. This limb of the test can be addressed by considering whether the Ministry's approach fell within a range of reasonable alternatives. In *R v Hansen*, Blanchard J noted that "a choice could be made from a range of means which impaired the right as little as was reasonably necessary". Tipping J dealt with minimal impairment in this way:
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> > [126] … The Court must be satisfied that the limit imposed …is no greater than is reasonably necessary to achieve Parliament's objective. I prefer that formulation to one which says that the limit must impair the right as little as possible. The former approach builds in appropriate latitude to Parliament; the latter would unreasonably circumscribe Parliament's discretion. In practical terms this inquiry involves the Court in considering whether Parliament might have sufficiently achieved its objective by another method involving less cost to the presumption of innocence.
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> [152] Finally, McGrath J put the point slightly differently when he said:
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> > [217] The second question concerning proportionality is whether the measure intrudes …as little as possible … The inquiry here is into whether there was an alternative but less intrusive means of addressing the legislature's objective which would have a similar level of effectiveness …
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> [153] A similar approach has been adopted in Canada. For example, in *RJR-MacDonald Inc v Canada*, McLachlin J said the requirement for minimal impairment meant that:
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> > [160] …the law must be carefully tailored so that rights are impaired no more than necessary. The tailoring process seldom admits of perfection and the courts must accord some leeway to the legislator. If the law falls within a range of reasonable alternatives, the courts will not find it overbroad merely because they can conceive of an alternative which might better tailor objective to infringement … On the other hand, if the government fails to explain why a significantly less intrusive and equally effective measure was not chosen, the law may fail.

[230] It is only where there are alternative, less harmful, means of achieving the Government's objective "in a real and substantial manner" that a law will fail the

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74 *Hansen v R*, above n 59, at [217].

75 *Ministry of Health v Atkinson* [2012] NZCA 184, [2013] 3 NZLR 546 at [151]-[153]. Cited with approval by O'Regan and Ellen France JJ in *New Health New Zealand v South Taranaki District Council* [2018] NZSC 59; [2018] 1 NZLR 948 at [133].

minimum impairment test.[76] The respondents say that the margin of appreciation plays a role at this stage of the analysis.[77]

[231] I accept Dr Bloomfield's evidence that there is a need for caution when extrapolating from the experience of any particular country whose circumstances may be different from those in New Zealand. While the Ministry of Health did regularly monitor and consider communications from WHO, other international medical bodies and scientific institutions of other governments, public health decisions in New Zealand have to be taken in a New Zealand context; that requires a New Zealand-specific assessment of the prevalence of Covid-19, health services capacity, population vulnerabilities and other factors.

[232] In the New Zealand context, Dr Bloomfield consistently advised the adoption of a multi-layered approach, with measures contained in the CPF sitting alongside high levels of vaccination, good hygiene, physical distancing, the wearing of masks, testing and, where appropriate, personal protective equipment, in order to minimise the spread of Covid-19 – "the more layers of protection in place, the harder it is for the virus to get through". Such an approach has been applied globally and in New Zealand and reflects that no public health intervention is 100 per cent effective at preventing disease.

[233] The evidence of Drs Town and Bloomfield clearly establishes the scientific support for the efficacy of vaccination and gathering limits in reducing the spread and harm of Covid-19. That evidence supports a conclusion that those measures are significantly more useful in achieving the objective than any one or combination of the alternatives proposed by the Orewa applicants (and supported by the FTBC applicants). As Justice Burrage put it in *Taylor v Newfoundland and Labrador*,[78] there is no simple, one size fits all solution to the effective management of a pandemic such as Covid-19. Similarly, in *Philip v Scottish Ministers*, Lord Braid said:[79] "I accept the respondents' submission that there is no international consensus as to how the pandemic should be legislated for".

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76 *Alberta v Hutterian Brethren of Wilson Colony*, above n 63, at [55].
77 *GF v Minister of Covid-19 Response* [2021] NZHC 2526, [2022] 2 NZLR 1 at [81].
78 *Taylor v Newfoundland and Labrador* [2020] NLSC 125 at [469].
79 *Philip v Scottish Ministers*, above n 40, at [117].

[234] The applicants' claims of arbitrariness and over-breadth by way of comparison with other activities are not borne out. The fact that some activities and businesses were allowed to proceed or remain open (with no or different restrictions) does not negate the rational connection between the restrictions on faith-based gatherings and their object. The restrictions on other activities in some cases reflected a different risk assessment. In other cases, the different restrictions reflected the essential nature of the activity.

Proportionality

[235] The final analysis requires a broad assessment of whether the benefits achieved by the restrictions are outweighed by the significance of the limitation of the applicants' right to manifest their religion. If those benefits outweigh the limitation on the applicants' rights, the limitation is proportionate and demonstrably justified under s 5 of the Bill of Rights Act.

[236] As the respondents acknowledge, it would be inappropriate for them or the Court to challenge the correctness of the applicants' beliefs. Having said that, the consultation with faith communities showed that many churches decided to operate with CVCs, to protect vulnerable congregants, and Professor Trebilco's evidence was that there is a range of views within the Christian community. That is relevant to the proportionality analysis. The gathering restrictions affected religious and non-religious alike. They may be a proportionate limit on the s 15 rights of a group whose views are not widely shared.

[237] The primary objective of the Order is to prevent, and limit the risk of, the outbreak or spread of Covid-19 in the community, in order to minimise death and serious illness and consequent impacts on the public health system. I have concluded that there was a rational connection between the restrictions and their object of decreasing the spread of Covid-19. That connection is convincingly set out in the evidence for the respondents. The applicants have not identified any alternative method that would be equally effective in achieving the objective. I conclude that the benefits of the CVC-related restrictions as introduced outweigh the limitation on the applicants' right and the limitation is proportional and demonstrably justified.

CVC-related restrictions after Omicron in the community

[238] The FTBC applicants say that once the Omicron variant had emerged in New Zealand in November 2021, the public health rationale for having a materially lower cap on numbers at a gathering, if one or more attendees were unvaccinated, was undermined. At that point the limitations in the Order became arbitrary and not rationally connected to the objective. Non-CVC gatherings should then have been subject to the same capacity limits as those applying to CVC gatherings (100 rather than 25), but using protective measures other than CVCs, particularly masks.

[239] The FTBC applicants also say that the government knew, at least in January 2022, that the effectiveness of the primary course of the vaccine against the Omicron variant was substantially reduced and a public health review in February 2022 concluded that there was no longer "a sufficient public health rationale to justify" a differentiated approach based on vaccination. However, the gathering limit was not removed until 2022.

[240] There are three aspects to FTBC's principal submission. First, the effectiveness of the vaccine in relation to the Omicron variant; second, what the government concluded in relation to the reduced effectiveness; and third, the fact that CVCs were not removed from the CPF until 4 April 2022.

Effectiveness of the vaccine against Omicron

[241] In early 2022 studies showed that while the vaccine provides some protection against symptomatic disease, its effectiveness in relation to Omicron is reduced, compared to Delta. The Minister received advice on 18 January 2022 that "critically, evidence suggests that two doses of Pfizer offer significantly less protection against infection from Omicron than from Delta… We do not have high levels of protection [against Omicron]."

[242] That advice was based on a number of international studies which showed that VE in relation to infection reduced more rapidly for Omicron than for Delta.[80]

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[80] Christian Hansen and others "Vaccine effectiveness against SARS-CoV-2 infection with the Omicron or Delta variants following a two-dose or booster BNT 162b2 or mRNA-1273

[243] The FTBC applicants say this data is not in dispute – it was all cited with approval in the Ministry of Health's advice and it ought to have triggered a change to the Order.

[244] Dr Town and Dr Bloomfield acknowledge that early evidence suggested that two doses of the vaccine offered significantly less protection against infection from Omicron than Delta and that Omicron was significantly more transmissible than Delta. While the severity of the disease for Omicron patients was reduced compared to those with Delta, the overall number of those in hospital was higher because of the much higher number of cases involved. Dr Bloomfield's advice to the Minister was that, in light of the risks presented by Omicron, a highly precautionary approach to settings under the CPF was warranted and that no areas should be moved to Green at that time. His advice was that a precautionary approach would reduce the number of higher risk gatherings and thus reduce the chances of rapid transmission across New Zealand if Omicron did enter the community. The initial suggestion from officials was that the appropriate response to Omicron emerging in New Zealand would be to increase restrictions, including capacity limits, under the CPF.

[245] The FTBC applicants rely on what the studies said about the effectiveness of the vaccine in preventing infection with Omicron. In response, Dr Town's evidence emphasised that VE is considered in relation to three aspects – its ability to prevent infection, prevent hospitalisation and prevent onward transmission from those who do become infected.

[246] Dr Town's evidence is that Omicron has a high number of mutations, including up to 32 mutations in the spike protein, which confers resistance to the currently available vaccines and may have higher transmissibility. Evidence by March 2022 indicated the Omicron variant is more transmissible and has a higher SAR than Delta.

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vaccination series: a Danish cohort study" (22 December 2021) <https://doi.org/10.1101/2021.12.20.21267966> at 6; United Kingdom Health Security Agency "SARS-CoV-2 variants of concern and variants under investigation in England" Technical Briefing 34 (14 January 2022) at 23; Yinong Young-Xu "Effectiveness of mRNA COVID-19 vaccines against Omicron among Veterans" (18 January 2022) at 4; and Nick Andrews and others "Effectiveness of Covid-19 vaccines against the Omicron (B.1.1.529) variant of concern" (14 December 2021) at 8.

[247] Dr Town says that Omicron may have a shorter serial interval than Delta and cases are likely to present differently: symptoms may be milder in previously infected and/or vaccinated individuals; United Kingdom data suggested about 25 per cent may be asymptomatic; and a sore throat is more common, while a loss of taste and smell is less commonly reported by Omicron cases than for Delta. The data indicated that hospitalisation and death rates were lower for Omicron than Delta, taking into account vaccination status and risk of severe disease.

[248] Dr Town says that rapid waning of VE occurs with Omicron, but a booster dose restores protection. The data demonstrates that:

(a) The vaccine effectiveness is around 55 per cent or more soon after two doses of Pfizer. This represents an epidemiologically important reduction in transmission. Vaccine efficacy wanes to levels unlikely to reduce infection risk and transmission within five to six months of the second dose.

(b) The vaccine efficacy is around 55 per cent to 69 per cent after the booster dose of Pfizer. The data also suggests that 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 per cent in those who had received a booster more than 10 weeks before.

[249] VE against hospitalisation appears to be 60-70 per cent after a primary vaccine course, but declines to around 45 per cent from 25 weeks after the second dose. Vaccine effectiveness against hospitalisation increases to around 90 per cent after a booster dose (including in those over 65 years of age).

[250] Dr Town concludes that two doses of the Pfizer vaccine continued to provide some protection and to assist in limiting the spread of Omicron within the community and reducing the incidents of hospitalisation. Two doses are less effective against Omicron than against Delta. A booster dose provides enhanced protection.

[251] Dr Bloomfield's evidence addresses the consequences of Omicron for the public health system and is relevant to the role of the vaccine in reducing the incidence of hospitalisation. With its very high levels of transmission, Omicron has resulted in an increased number of people requiring hospital level care. In addition to people who require hospital level care, increased case numbers increase the number of people who require primary care, for example from their general practitioner or local pharmacist. The number of hospitalisations, particularly at the first peak of the Omicron outbreak, together with the absence of staff due to quarantine and isolation, placed a significant strain on the New Zealand healthcare system. Reducing that impact, Dr Bloomfield said, remained an important part of New Zealand's public health response to Covid-19 which has represented an unprecedented public health challenge.

[252] In conclusion on this point, the evidence of reduced VE for Omicron, compared with Delta, when taken together with the evidence about the ongoing benefits of vaccination in the Omicron context, does not support the submission that there was no longer a sufficient public health benefit to justify continued use of CVCs.

What the advice to government said

[253] Second, the FTBC applicants point to a public health review on 28 February 2022, reported in a memorandum by Ministry of Health officials to Dr Bloomfield on 4 March 2022. They say that memorandum should have triggered the Minister to immediately remove CVCs from the CPF.

[254] FTBC emphasises the following paragraph of the memorandum, under the heading "Covid-19 Vaccine Certificates":

> 33. Given there is now significant community transmission, but with very high rates of vaccination, the use of CVCs do not provide the same population protection. This brings the validity of retaining CVCs as a public health measure, at this point in time, into question. The Director of Public Health's advice is that, given the very high rate of vaccination nationally and the current definition of 'up-to-date vaccination status' (which only includes 2 doses of vaccine, and is now under review), there is technically not a sufficient public health rationale currently to justify CVCs being used to prevent entry to certain premises during this phase of the response.

[255] And the linked, noting recommendation:

> **Note** the Director of Public Health's advice that, given the very high rate of vaccination nationally, there is not a sufficient public health rationale currently to justify COVID Vaccine Certificates (CVCs) being used to prevent entry to certain premises during this phase of the response.

[256] FTBC's reliance on the memorandum is selective and, for that reason, inaccurate and misleading. The paragraph immediately following said:

> 34. However, it is important to note that you will be receiving further advice relating to vaccine tools, including boosters, the definition of 'up-to-date vaccination status', and mandates for affected group of workers which should still remain at this point. This further work, particularly if a requirement to have been boosted is included in the definition of 'up-to-date vaccination status', could mean that only 73 per cent of New Zealanders would be considered fully vaccinated. If so, the original public health rationale for CVCs would be restored immediately since a significant number of New Zealanders would not be considered fully vaccinated.

[257] That paragraph was reflected in a recommendation (which the Minister ticked "yes"), in the following terms:

> **Agree** that, in light of the ongoing work to define an 'up-to-date vaccination status', it is too early to conclude that there is an insufficient public health rationale for CVCs to be used to prevent entry to certain premises.

[258] Further advice from Ministry of Health officials to Dr Bloomfield on 14 March 2022 was that "while the immediate social and legal justification for vaccine passes and mandates is diminishing due to high vaccination rates, with winter approaching, the borders re-opening and existing immunisation levels waning, removing them at this time is not advisable" and "at least until it decides to step down from Red to Orange settings of the CPF, Government should continue with the current use of COVID-19 Vaccinate Certificates (CVCs) domestically."

[259] The 4 March 2022 memorandum does not support FTBC's submission. It does however demonstrate that the Order was being kept under review as required by s 14(5) of the Act.

Delay in implementing decision to remove requirement for CVCs

[260] The third issue raised by the FTBC applicants is the apparent delay between Cabinet's agreement on 21 March 2022 to remove CVCs from the CPF and the actual removal on 4 April 2022.

[261] The 21 March 2022 paper from the Minister to Cabinet makes plain why the gap between the decision and it taking effect was required:

> [15] I propose that MVPs are removed from the Framework at 11:50 pm Monday 4 April 2022. By this date we are very likely to have confidence that we have moved past the Omicron peak and allows time for sectors and agencies to put in place the guidance and workplace requirements they need to manage residual COVID-19 risk.

[262] That aspect of FTBC's challenge must also fail.

[263] Finally, I consider several subsidiary points raised by FTBC which they say also render the CVC-related restrictions arbitrary and not rationally connected to their purpose.

Offence provisions

[264] From 4 December 2021 the COVID-19 Public Health Response (Infringement Offences) Regulations 2021 provided that a breach of the number limit gathering rules for CVC gatherings was classified as a medium risk offence and for non-CVC gatherings it was classified as a high risk infringement offence.

[265] Although not pleaded in their statement of claim, in submissions the FTBC applicants say this rendered the gathering limits in the CPF arbitrary because breaching the capacity limits at nightclubs, bars, restaurants and gyms was not an infringement offence.

[266] Because of the late introduction of this aspect of the claim the respondents were not able to bring evidence about the policy work that underlay the different treatment. Nevertheless, they say on its face the claim is not supported. At the Red setting, CVC gatherings could have up to 100 people and non-CVC gatherings up to 25. Nightclubs, bars, restaurants and gyms could have up to 100 people with CVCs, but were required to close without using CVCs.[81] Hospitality and gyms could not legally operate at the Red setting without requiring CVCs, so the risk at those venues was lower. The respondents also point to the different levels of risk.

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[81] Order, above n 1, sch 7, part 3, subparts 1 and 3.

[267] In the absence of evidence on the point, I am not persuaded that differing enforcement mechanisms for breaches of rules in these different contexts make the Order arbitrary or not rationally connected to its purpose.

Gatherings at private dwellings

[268] The FTBC applicants also say the fact that gatherings at private dwellings are not subject to the density limit imposed on other gatherings, including faith-based gatherings, makes the gathering limits arbitrary. They say that a gathering of 100 vaccinated people in a small private dwellinghouse – the "highest risk setting for transmission of the virus" – is permitted, but the Order prevents a faith-based gathering of more than 25 people, where one person is unvaccinated, in a large church hall.

[269] As discussed above, the respondents' evidence is that the distinction is a practical one: requiring people to calculate the square footage of their home to have a private gathering would undercut the need for clear and uncomplicated health measures and make it harder for individuals to ascertain whether they were compliant. In contrast, gatherings at other venues are more likely to be formally organised and able to calculate the size of the venue. In addition, gatherings at private dwellinghouses are easier to contact trace.

[270] The respondents also refute the claim regarding the risk setting of private dwellinghouses. Gatherings in private dwellinghouses are included in the "private gatherings" category, with a SAR of 10.4 per cent,[82] not the household settings category, with a SAR of 45 per cent.

[271] The FTBC applicants also raise doubt about whether the gatherings rules apply to gatherings at private dwellinghouses at all, given that cl 42(4)(b) of the Order provided that the gathering rules do not apply to gatherings at premises referred to in s 12(2)(c) of the Act, and s 12(2)(c) includes "premises […] used solely as a private dwellinghouse" in those premises that may not be closed by an order under s 11(1)(e)(i) of the Act.

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[82] As shown in the Ministry of Health's first Delta Outbreak SAR Analysis of 19 October 2021.

[272] The respondents concede a drafting issue but say it is clear that cls 46 and 47 are intended to apply to gatherings at private dwellinghouses. Section 11(1)(b)(ia) of the COVID-19 Act empowers the Minister to make orders requiring persons to permit access to premises only under specified conditions: nothing in the COVID-19 Act excludes dwellinghouses from the premises that may be subject to such conditions. By contrast, the effect of s 12(2)(c) and (d) is that private dwellinghouses, prisons, courts and parliamentary precincts cannot be closed, or have their opening subject to conditions (in the same way that commercial premises can) by a COVID-19 Order.

[273] Because the issue was not pleaded, there is no evidence from the respondents on the point. I am satisfied that a possible technical drafting issue cannot make the restrictions applying to faith-based gatherings arbitrary or unconnected to their purpose.

Conclusion as to CVC-related restrictions after Omicron in the community

[274] For the reasons set out above, I have found that the limits imposed on the applicants' s 15 rights by the CVC-related restrictions as introduced were demonstrably justified.

[275] I am satisfied on the evidence that, after the Omicron variant was circulating in the community, there remained a rational connection between the CVC-related restrictions and the purpose of the restrictions.

[276] As I have concluded in relation to the Orewa applicants' first cause of action, while there were a range of other, less restrictive, measures relevant to achieving that purpose, they would not have had a similar level of effectiveness.

Limit in due proportion to the importance of its objective

[277] Finally, as with the Orewa applicants' claim, the Court is required to step back and assess whether, in the round, the restrictions after Omicron was in the community were in due proportion to the importance of their objective.

[278] That assessment remains the same. As McLachlin CJ noted, in *Hutterian Brethren*, the Canadian Charter "does not demand that the limit on the right be perfectly calibrated, judged in hindsight, but only that it be "reasonable" and "demonstrably justified".[83] The same is true of s 5 of the Bill of Rights Act.

[279] Although s 13 of the Bill of Rights Act is not relied on by the applicants, the distinction between the ss 13 and 15 rights is important:[84]

> … It is only the external, *manifestation,* aspect of the right that can be subject to 'such limitations as are prescribed by law and are necessary in a democratic society…'. A restriction on the internal freedom of thought cannot be justified; the right is absolute.

[280] And Lord Nicholls explained in *R (Williamson) v Secretary of State for Education,* the distinction between the two aspects of the right is significant:[85]

> *… because the way a belief is expressed in practice may impact on others. …* So in a pluralist society a balance has to be held between freedom to practise one's own beliefs and the interests of others affected by those practices.
>
> (Emphasis added)

[281] As I noted earlier in this judgment, s 15 does not contain an explicit limitation regarding the rights of others (as the ICCPR and ECHR do) but the s 5 analysis necessarily requires the Court to consider how the manifestation of the applicants' religious beliefs might impact on others.

[282] I am in no doubt about the significant impact of the restrictions on all of the applicants and the members of their congregations.[86] But faith-based gatherings are not self-contained events. Members of a particular faith community go back to their families, and workplaces and other social settings. Risks incurred in places of worship impact on others. It is that potential to affect others – the rights of the broader public

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83 *Alberta v Hutterian Brethren of Wilson Colony*, above n 63, at [37].

84 *New Zealand Health Professionals Alliance Inc v Attorney-General of New Zealand*, above n 35, at [65].

85 *R (Williamson) v Secretary of State for Education* [2005] UKHL 15, [2005] 2 AC 246 at [17].

86 The FTBC applicants refer by analogy to the effects on congregants of closure of places of worship described in *Philip v Scottish Ministers*, above n 40. That case involved a complete closure of places of worship.

to life and health and their interests in an effectively functioning health system – that renders the possibility of qualification of the applicants' rights necessary.[87]

[283] Finally, it is relevant to note that, as well as being subject to ongoing review (fortnightly as at mid-April by the COVID-19 Protection Framework Assessment Committee),[88] the restrictions were temporary (four months), and in the context of what is almost certainly the worst public health crisis in at least one hundred years. Overall, I am satisfied on the evidence that the CVC-related restrictions as introduced, and as continued after Omicron arrived in the community, continued to be a proportionate response to the public health risk.

Failure to consider s 15 of the Bill of Rights Act/Error of law

[284] The Orewa applicants say that the Minister failed to consider the nature of the s 15 right as "the right of churches to collectively assemble, [or] the right [of] people within those churches to assemble with all others with whom they would wish to assemble to manifest their religion."

[285] The Orewa applicants submit that there is nothing to show that the Minister thought about the right to manifest religion as a matter of religion, rather than as a social gathering. They point, for example, to his evidence that he rejected advice to impose a gathering limit of 10 (choosing 25 instead) as there were "proportionality concerns given the importance of social connection (specially at Christmas)", as the 10 person limit "was impractical for large families that may want to come together for a gathering". They say that the consultation with communities of faith overlooked mainstream evangelicalism, aside from National Church Leaders Aotearoa, the InterChurch Bureau and possibly a Baptist church.

[286] The Orewa applicants say the Minister made an error of law by defining gatherings to include both faith-based gatherings and secular activities such as sporting and recreation clubs. As already discussed, the Orewa applicants and FTBC challenge the definition of "gathering". In the definition of "gathering" faith-based

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87 *New Zealand Health Professionals Alliance Inc v Attorney-General,* above n 35, at [86]. See also *R (Williamson) v Secretary of State for Education*, above n 85, at [84] and [86].

88 COVID-19 Act, s 14(5).

gatherings were listed among other types of gathering that have nothing to do with religion or belief and which are not provided explicit protection by the Bill of Rights Act. By placing the right to manifest religion alongside activities such as the ability to participate in sport, rather than alongside other protected rights subject to fewer restrictions (such as education) the Minister improperly categorised the right.

[287] In their submission, the Minister's statements tended to trivialise or ignore the importance of the right to worship. In particular, the Orewa applicants say that the Order treats the right to worship unequally, compared to other legally protected rights such as access to food, healthcare, the ability to move freely, find shelter, access justice and receive education. They say that the rights of owners and operators of business and of people who wanted to get on a plane, bus or other public transport (some for holiday or entertainment purposes) were respected at a level not afforded to the right to manifest religion and, in fact, were elevated above the right to manifest religion.

[288] Three streams of targeted consultation on the framework were held with places of worship. The Hon Aupito William Sio, Minister for Pacific Peoples, and his office engaged with Pasifika church leaders. The Hon Priyanca Radhakrishnan, Minister for Diversity, Inclusion and Ethnic Communities, and her office engaged with representatives from the Muslim, Hindu, Sikh, Jewish and Buddhist faiths. Finally, Sarah Sparks, as the Chair of the Community Panel (established in July 2021 by DPMC to provide a diverse range of perspectives on different aspects of the Covid-19 response), engaged particularly with the Catholic Church.

[289] The 14 October 2021 briefing to the Minister from DPMC and the Director-General reported back on stakeholder engagement on CVCs. In relation to faith-based organisations, the Advice Paper noted that there had been "mixed feedback" from religious organisations: "Some strongly opposed any mandatory use of CVCs or negative COVID-19 test to enter their premises as this would impact the freedom of religious expression. Others were interested in having an option to introduce vaccine requirements, should they wish to." The briefing also noted a concern about vaccination status being the basis for entry for people who are vaccinated "as they consider there is no benefit as vaccines do not prevent infection per se".

[290] It is clear that the applicants' views are genuinely held. The "correctness" or "validity" of those beliefs is not challenged. But as Professor Trebilco's evidence notes, the applicants' views are not necessarily accepted by all Christians, or even a majority of them.[89] I am satisfied that the substance of the applicants' concerns was put to and considered by the Minister. I also accept the respondents' submission that the requirement that a COVID-19 Order does not limit, or is a justified limit on, rights affirmed by the Bill of Rights Act cannot extend to a requirement that the Minister consider the religious views of every individual or group potentially affected by the Order.

Unreasonableness

[291] The FTBC applicants allege that the Minister acted unreasonably by making distinctions in the Order that are not supported by public health principles. FTBC's submissions amended the argument somewhat, covering the same submissions as in relation to their s 15 Bill of Rights Act claim.

[292] I agree that, as in *NZDSOS*,[90] this ground does not meaningfully add to the arguments about whether the s 15 rights were justifiably limited.

Exemption under cl 105 of the Order

[293] Finally, the Orewa applicants say the Director-General did not grant them an exemption pursuant to cl 105 of the Order. Clause 105 provides:

> Subpart 2—Director-General may grant exemptions
>
> **105 Power for Director-General to grant exemptions from this order**
>
> (1) The Director-General may exempt any class of persons, businesses, services, or goods (or any person, business, service, or goods) from the application of any provision of this order or from the requirement to comply with any provision of this order in accordance with this clause.
>
> (2) The Director-General may grant an exemption if satisfied that—
>
> (a) the exemption is necessary or desirable in order to promote the purposes of the Act or the purposes of this order; and

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89 Professor Trebilco particularly disputes Dr Flannagan's evidence that the effect of the Order was to require excommunication by excluding people from communal fellowship and worship.

90 *NZDSOS v Minister for Covid-19 Response*, above n 60, at [144].

(b) the extent of the exemption is not broader than is reasonably necessary to address the matters that gave rise to the exemption.

…

[294] The Orewa applicants' statement of claim does not seek any relief against the Director-General and Ms Flannagan confirmed at the hearing that the Orewa applicants had not applied for an exemption under cl 105. For that reason, the respondents have not had the opportunity to present evidence on exemptions. Nor is it clear whether the pleading is that the Director-General should have made an exemption under cl 105 for the applicants specifically, or for those who have a religious belief that conflicts with the gathering restrictions, or that faith-based gatherings generally ought to have been exempted from the gathering restrictions.

[295] Given these deficiencies, any claim in relation to cl 105 cannot succeed.

Conclusions

[296] In relation to the Order as introduced, I conclude that the Order was not an unjustifiable limitation on the applicants' rights under s 15 of the Bill of Rights Act.

[297] In relation to Order once Omicron had arrived in the community, I conclude that the Order was not an unjustifiable limitation on the applicants' rights under s 15 of the Bill of Rights Act.

[298] As noted earlier in this judgment, the Order in its current form includes a gathering limit at Red. New Zealand is currently at Orange. A shift to Red would occur in the event of the Orange setting no longer containing the virus. If and when that were to occur, the Court's consideration of any further challenge to the Order would necessarily be context and fact-specific.

Costs

[299] The respondents acknowledge that, given the fundamental rights at issue and the public interest in these matters, they do not seek costs in the proceeding.

Gwyn J