Neutral Citation Number: [2009] EWCA Civ 795

Case No: C1/2008/1307

**IN THE SUPREME COURT OF JUDICATURE**
**COURT OF APPEAL (CIVIL DIVISION)**
**ON APPEAL FROM THE ADMINISTRATIVE COURT**
**OF THE QUEEN'S BENCH DIVISION**
**(Lord Justice Pill and Mr Justice Silber)**
**CO/2459/2007 and CO/5522/2007**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/07/2009

**Before :**

**LORD CLARKE OF STONE-CUM EBONY MR**
**LORD JUSTICE KEENE**
and
**LORD JUSTICE MOSES**

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**Between :**

| | |
|---|---|
| **R (N)** | **Claimant/ Appellant** |
| **- and -** | |
| **THE SECRETARY OF STATE FOR HEALTH** | **Defendant/ Respondent** |
| **And between:** | |
| **R (E)** | **Claimant/ Appellant** |
| **-and-** | |
| **NOTTINGHAMSHIRE HEALTHCARE NHS TRUST** | **Defendant/ Respondent** |
| **- and -** | |
| **EQUALITY AND HUMAN RIGHTS COMMISSION** | **Intervener** |

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**Paul Bowen** and **Azeem Suterwalla** (instructed by **Scott-Moncrieff, Harbour & Sinclair**) for **N** and (instructed by **Cartwright King**) for **E**
**Jonathan Swift** and **Karen Steyn** (instructed by the **Department of Health**) for the **Secretary of State for Health**
**David Lock** and **Nageena Khalique** (instructed by **Mills & Reeve**) for the **NHS Trust**
**Helen Mountfield,** by written submissions, for the **Intervener**
Hearing dates: 25 and 26 February 2009

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## Judgment

**Lord Clarke of Stone-cum-Ebony MR and Lord Justice Moses:**

**Introduction**

1. This appeal arises out of a decision of the Divisional Court (Pill LJ and Silber J) handed down on 20 May 2008 on applications for judicial review against the Nottinghamshire Health Care NHS Trust ('the Trust') and the Secretary of State for Health ('the Secretary of State') challenging the ban on smoking at Rampton Hospital ('Rampton'). The applicants for judicial review were B, G and N, who either were or had been detained at Rampton. The applications failed. Permission to appeal was refused by the Divisional Court and by Mummery LJ on paper but was subsequently granted by Tuckey and Smith LJJ after an oral hearing. The appellants were initially G and N but G has since indicated that he wishes to discontinue his claim against the Trust. Since then arrangements have been made with the Legal Services Commission to substitute E for G. We have concluded that that is a sensible step to take and therefore grant the application for substitution.

2. The Divisional Court dismissed claims for judicial review and under section 7 of the Human Rights Act ('the HRA') as follows:

   i) in N's case, judicial review of regulation 10 of the Smoke-Free (Exemption & Vehicles) Regulations 2007 ('the Exemption Regulations') in so far as, in the case of mental health units, it introduced only a temporary exemption, until July 2008, rather than a permanent exemption from the requirements of the Health Act 2006 ('the 2006 Act') that all premises used by the public be "smoke-free" from 1 July 2007; and

   ii) in E's case, judicial review of the Trust's policy banning smoking at Rampton with effect from 31 March 2007.

3. As is well known, Rampton is one of three high security psychiatric hospitals in England and Wales established by the Secretary of State for Health under what is now section 4 of the National Health Service Act 2006. The other two are Broadmoor and Ashworth. Like the Divisional Court, we will assume that similar policies are followed in all three hospitals. As the Divisional Court said at [3] of the judgment of the court delivered by Pill LJ, section 4 provides, so far as material:

   > "(1) The Secretary of State's duty under section 1 includes a duty to provide hospital accommodation and services for persons who -"
   >
   > (a) are liable to be detained under the Mental Health Act 1983, and
   >
   > (b) in the opinion of the Secretary of State require treatment under conditions of high security on account of their dangerous, violent or criminal propensities.
   >
   > (2) The hospital accommodation and services mentioned in subsection (1) are referred to in this section and

> paragraph 15 of Schedule 4 (NHS trusts) as "high security psychiatric services.
>
> (3) High security psychiatric services may be provided only at hospital premises at which services are provided only for the persons mentioned in subsection (1)."

The thrust of the appellants' case is that the Exemption Regulations and the Trust's policy unlawfully infringe their rights under article 8 and/or article 14 of the European Convention on Human Rights ('the Convention'). In the context of article 14 it is said that the Secretary of State unlawfully discriminates between those detained at Rampton under the Mental Health Act 1983 ('the MHA') and those in prison.

4. Section 3 of the MHA provides for the detention of mental health patients in a civil context. Section 37 provides for hospital orders made in criminal proceedings after conviction or findings of insanity or unfitness to plead. Such orders are made with or without restrictions under section 41. Sections 47 and 48 provide for transfers for convicted prisoners, prisoners on remand and other detainees such as immigration detainees and section 49 provides for restrictions on those transferred under section 47 or 48 having the same effect as a restriction order under section 41.

**Smoking ban - the statutory framework**

5. The Divisional Court set out the relevant provisions of the 2006 Act and the Exemption Regulations at [5] to [9]. We take this account largely from that section of the judgment. Section 1 of the 2006 Act makes provision for the prohibition of smoking in certain premises, places and vehicles. Section 2 provides for "smoke-free premises". Premises are defined by section 2(1) and (2) as smoke-free *inter alia* "if they are open to the public" and in certain circumstances if they are used as a place of work. They must be smoke-free all the time. Section 2(4) provides:

> "In any case, premises are smoke-free only in those areas which are enclosed or substantially enclosed."

It is common ground that Rampton is a place of work and must be smoke-free under the 2006 Act unless exempted by regulations.

6. Section 3 provides for some premises, or areas of premises, not to be smoke-free, despite section 2. It provides, so far as relevant:

> "(1) The appropriate national authority may make regulations providing for specified descriptions of premises, or specified areas within specified descriptions of premises, not to be smoke-free despite section 2.
>
> (2) Descriptions of premises which may be specified under subsection (1) include, in particular, any premises where a person has his home, or is living whether permanently or temporarily (including hotels, care

homes and prisons and other places where a person may be detained). …

(6) The regulations may provide, in relation to any description of premises or areas of premises specified in the regulations, that the premises or areas are not smoke-free

(a) in specified circumstances,

(b) if specified conditions are satisfied, or

(c) at specified times,

or any combination of those.

(7) The conditions may include conditions requiring the designation in accordance with the regulations, by the person in charge of the premises, of any rooms in which smoking is to be permitted."

The expression "other places where a person may be detained" naturally includes Rampton and indeed other mental hospitals where patients are detained under the MHA. It is important to note that, as the Divisional Court observed, the appellants do not say that the 2006 Act is itself incompatible with their rights under the Convention.

7. Their complaint is about the Exemption Regulations, which were made by statutory instrument under section 79 of the 2006 Act. Section 79(4) requires that such regulations must be subject to a positive resolution of each House of Parliament. The Exemption Regulations, which are headed "Public Health England", were made on 7 March 2007 and came into force on 1 July 2007. The Exemption Regulations contain exemptions for private accommodation, accommodation for guests and club members, specialist tobacconists and research and testing facilities: see regulations 3, 4, 7 and 9 respectively. The relevant regulations for present purposes are regulations 5 and 10.

8. Regulation 5 is headed "Other residential accommodation" and, so far as relevant, provides:

"(1) A designated room that is used as accommodation for persons aged 18 years or over in the premises specified in paragraph (2) is not smoke-free.

(2) The specified premises are –

(a) care homes as defined in section 3 (care homes) of the Care Standards Act 2000;

(b) hospices which as their whole or main purpose provide palliative care for persons resident there who are suffering from progressive disease in its final stages; and

(c) prisons."

The meaning of "designated room" is specified in paragraph (3).

9. The appellants' complaint focuses on the difference between the exemptions granted to prisons under regulation 5 and the temporary exemptions granted to mental heath units under regulation 10. That regulation is headed "Temporary exemption for mental health units" and provides:

> "(1) A designated room for the use of patients aged 18 years or over in residential accommodation in a mental health unit is not smoke-free.
>
> (2) In this regulation -
>
> "designated room" means a bedroom or a room used only for smoking which –
>
> (a) has been designated in writing by the person in charge of the mental health unit as being a room in which smoking is permitted;
>
> (b) has a ceiling and, except for doors and windows, is completely enclosed on all sides by solid, floor-to-ceiling walls;
>
> (c) does not have a ventilation system that ventilates into any other part of the premises (except any other designated room);
>
> (d) is clearly marked as a room in which smoking is permitted; and
>
> (e) does not have any door that opens on to smoke-free premises which is not mechanically closed immediately after use; and
>
> "mental health unit" means any establishment (or part of an establishment) maintained wholly or mainly for the reception and treatment of persons suffering from any form of mental disorder as defined in section 1(2) of the Mental Health Act 1983.
>
> (3) Paragraphs (1) and (2) shall cease to have effect on 1st July 2008."

10. The critical part of regulation 10 for present purposes is paragraph (3) because the appellants' complaint is that it was discriminatory and unlawful to provide only for a temporary exemption, especially by contrast with prisons where the exemption granted by regulation 5 is unlimited in time. As the Divisional Court noted at [10], by virtue of the nature of their mental disorder and the risks they have been held to pose

to the public, those admitted to Rampton tend to be detained there for a considerable time. The average length of stay is eight years and in some cases much longer. The Divisional Court noted that it was submitted, with justification, that Rampton should be regarded as their home. It referred in this regard to section 3(2) of the 2006 Act (quoted above), which contemplates homes or residential accommodation of various kinds, including prisons and mental health units like Rampton, as premises which may be exempted from the requirement to be smoke-free.

11. The appellants rely upon article 8 of the Convention, either standing alone or in conjunction with article 14. Articles 8 and 14 provide as follows:

> "*Article 8 – Right to respect for private life*
>
> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.
>
> *Article 14 – Prohibition of discrimination*
>
> The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status"

**The policy of the Trust**

12. The Trust issued a policy for Rampton in December 2006, which has been amended from time to time since then. It was entitled 'Smoke-free Policy' and came into force with effect from 31 March 2007, which was of course after the Exemption Regulations were made but before they came into force on 1 July 2007. As at 1 April 2007 there was, as we understand it, no statutory provision in force requiring the Trust, either to implement a smoke-free policy, or, indeed, to provide facilities for smokers. The policy was, however, of course introduced in the context of the smoke-free debate, the approach of the Secretary of State and both the 2006 Act and the draft Exemption Regulations.

13. The essence of the policy is that, save where individual exceptions are permitted on clinical grounds, smoking has been prohibited for both staff and patients throughout Trust premises from 1 April 2007. Unlike the 2006 Act, which only applies inside, the policy applies throughout the Trust estate, both inside and outside its buildings. The Trust policy was introduced both as a matter of discretion by the Trust in setting internal rules which are consistent with government policy to create a smoke-free NHS and to comply with the anticipated requirements of the 2006 Act. As stated at the beginning of the policy document, the policy sets out the Trust's "commitment and framework for creating and maintaining a

completely smoke free environment (buildings and grounds), for the health benefits of staff, patients and visitors by 31 March 2007". Paragraph 1.2 is in these terms:

> "The aims of the policy are to:
>
> - protect and improve the physical and mental health of staff, patients, visitors and contractors;
> - protect both smokers and non-smokers from the danger to their health of exposure to second-hand smoke;
> - encourage an environment conducive to giving up smoking, which provides full support to staff and patients who want to give up smoking;
> - contribute to the overall management of fire risk in Trust premises."

14. In paragraph 5 the policy did contemplate the possibility of some exemptions. As the Divisional Court observed at [11], on 19 March 2007 the Trust issued guidance to Rampton on the "implementation of patient exceptions" to the smoke-free policy. Like the Divisional Court, we assume 'exceptions' was intended to have the same meaning as 'exemptions'.

15. In the document, reference is made to the Trust's smoke-free policy which provides that exemptions:

> "… for long stay mental health patients in an acute psychiatric state or terminally ill patients exceptions may be made on a case-by-case basis. However, no blanket exception will be allowed for particular categories of patients. … The policy should allow for flexibility in exceptional circumstances."

16. The exemptions are more fully stated as follows in cases of "Acute Psychiatric State" and "Terminal Illness": see the judgment of the Divisional Court, where the details are set out at [11]. In the same document, a procedure is set out for dispensing and administration of cigarettes, which includes guidance quoted by the Divisional Court at [12].

> "5.9 The patient may only smoke outdoors. The location to be chosen should be discrete as the sight and smell of a patient smoking may upset other patients.
>
> 5.10 The Nurse will retain the cigarette until the patient has been safely escorted outdoors, when the cigarette will be given to the patient and then lit by the Nurse who will retain the ignition source.
>
> 5.11 When the patient has finished smoking the Nurse will ensure that the cigarette is extinguished in a suitable ashtray and disposed of safely in an appropriate bin.

> 5.12 The staff and patient will return to the ward.
>
> 5.13 Once the decision has been made for the patient to stop smoking then the remaining cigarettes will be returned to the [patients'] Shop for destruction."

17. Thus the effect of the Trust's policy was to ban smoking subject to very few exemptions. Since 31 March 2007 no smoking has been permitted outside, all previously designated smoking rooms have been off-limits, tobacco products are no longer available at the hospital shop and have been banned and no exemption had been granted as at the time of the hearing before the Divisional Court. We were not told the up to date position but it is clear that exemptions are likely to be granted only in very rare cases. We should add that we understand that the designated smoking rooms have not been dismantled pending the outcome of this litigation. Moreover, paragraph 5.5 of the policy was amended in April 2007 to read:

> "In circumstances where a patient falls within an exemption category and this is recorded in their care plan appropriately, they will only be permitted to smoke outdoors and will not be able to smoke within any of the Trust's buildings."

It is the appellants' case that the exemption categories are too restrictive of their right to smoke to comply with article 8.

**The appellants' case**

18. In summary the appellants' case is that the smoking ban was introduced at Rampton as a consequence both of the Trust's policy and of the Exemption Regulations and that the introduction of the ban was a breach of their rights under article 8, whether alone or taken together with article 14. The challenge is to the combined effect of the policy and the Exemption Regulations. The Exemption Regulations only prohibit smoking within enclosed spaces, thus permitting smoking to continue in outside spaces. The Trust's policy bans smoking both inside and out, subject to certain very limited exceptions referred to above. The basis for the ban on smoking inside is that the Exemption Regulations ban smoking inside. The basis for the ban on smoking outside is that security reasons prevent the Trust from being able to permit patients to smoke outside. The appellants seek relief that would have the effect, first, of modifying regulation 10 of the Exemption Regulations so as to continue in force the exemption permitting smoking in mental health units in 'designated rooms' in cases where it is impracticable for patients to be able to smoke outside. The Trust (and all other mental health units) would then need to give effect to that exemption by amending its policy to enable patients to smoke in designated rooms within the hospital.

19. The Divisional Court dismissed the application in a single judgment and the grounds of appeal are identical in both cases. The appellant N invites the court to give him permission to argue a further point, which arises if his appeal fails on the basis that article 14 is not engaged because smoking does not fall within the ambit of article 14. That point is that the Exemption Regulations are irrational and contrary to the common law principle of equality in so far as they proscribe smoking in mental health

units while permitting it to continue in other residential public spaces such as prisons and care homes. We return to this point below.

**The position of the Trust**

20. It seems to us to be convenient to consider first the position of the Trust and, in particular, to ask the question whether, as at 1 April 2007, the Trust's policy was lawful. As already stated, the position then was that it would have been lawful to permit smoking at Rampton under regulation 10 of the Exemption Regulations, which were not yet in force.

21. In this regard the Trust's position can be summarised in this way. The Trust is part of the NHS and developed its policy for all Trust premises, of which there are over 100, including Rampton, as part of the move, promoted by the Secretary of State, to promote smoke free hospitals within the NHS and not primarily as a response to the 2006 Act. The legal relationship between the appellants and the Trust is different from that between the appellants and the Secretary of State. The Trust seeks to develop a therapeutic relationship with the appellants which arises out of the duty of care which it owes directly to them, including the duty to take reasonable care to prevent them from self harm. The reasonableness and lawfulness of the Trust's policy thus falls to be judged separately from the lawfulness of the Secretary of State's legislative acts. The Trust does not operate prisons, care homes or hospices. Accordingly, complaints under article 14 which are based on comparisons with residents in such places do not engage the Trust. The Trust further says that it cannot have been acting unlawfully as from July 2008 because of the removal of the exemption in regulation 10(3) of the Exemption Regulations.

**The facts**

22. In their skeleton argument the appellants refer *inter alia* to [15] to [32] of the judgment of the Divisional Court in which it set out the evidential background through a series of public documents. The documents speak for themselves and we attach the Divisional Court's summary as Appendix A to this judgment. They demonstrate with clarity the risks that smoking poses both to the smoker and to those exposed to smoking or, in the jargon, to second-hand smoking or 'SHS'. So, for example, according to a 1998 White Paper, those who smoke regularly and who then die from smoking lose on average 16 years of their life expectancy when compared with non-smokers and, in December 2005, the House of Commons Health Committee reported that SHS caused at least 12,000 deaths a year in the United Kingdom, of which at least 500 were due to the presence of smoke in the workplace: see the judgment at [16] and [17].

23. The research conducted when the 2006 Act was under consideration was referred to at [19], together with the view of the House of Commons Health Committee, based on the research, that public support was moving "rapidly and decisively in favour of a comprehensive ban in public places and workplaces". The Divisional Court also set out the consideration given to human rights concerns: see in particular [19] and the statements of ministers quoted from Hansard at [20]. They included the statement that the issue was how to strike the right balance between protecting people from harm on the one hand and protecting people's freedom of choice on the other.

24. At [22] to [32] the Divisional Court referred to the consultation on the proposed Exemption Regulations and set out how the approach of the Department of Health changed. It was initially to exempt designated rooms within mental health units from the smoke-free requirements of the 2006 Act on the basis that the exemption would be permanent as in the case of prisons, care homes and hospices. However, 65 per cent of the responses to the consultation favoured either no exemption for mental health units or only a time limited exemption. The views of the Disability Rights Commission ('DRC') were summarised at [25] and [26], together with the DRC's conclusion that the relevant material showed "that a very good reason is needed to depart from the principles of a smoke-free NHS". The views of the Royal College of Psychiatrists to similar effect were summarised at [27] and [28]: see in particular the quotation at [28], which concluded that the object should be to achieve smoke-free status in all mental health facilities within a reasonable period of perhaps two to three years. Of particular significance is the quotation at [29] from the King's Fund study, which focused on smoke-free policies in psychiatric units. It is worth repeating the quotation here:

> "Epidemiological studies suggest chronic smoking is associated with agoraphobia, generalised anxiety disorder and panic disorder ... smokers have higher rates of and experience more severe depression and are more likely to think about suicide and have higher suicide rates"

25. The Divisional Court noted at [30] that there was a substantial body of opinion which the Secretary of State would be expected to take into account supporting an indefinite or time-limited exemption. Finally, we should note the Divisional Court's statement at [31] that the Mental Health Act Commission expressed the view that patients who are deprived of their liberty under the MHA should not, as a consequence, be deprived of the choice to smoke. Other considerations put forward were that not being able to smoke can add to the distress of patients at a difficult time and might be counter-productive to the patient's care and welfare.

26. As appears in appendix A, the Divisional Court then set out at [33] to [39] a summary of the evidence which it is not necessary to repeat in the body of this judgment.

**The issues**

27. The issues can be seen from the grounds of appeal, which assert that the Divisional Court erred in law in holding that

   i) smoking is not an activity within the scope of the right to respect for home or private life under article 8;

   ii) the failure to permit smoking facilities in mental health hospitals does not constitute an interference with the right to respect for home and private life under article 8;

   iii) such a failure does not come within the 'ambit' of article 8 for the purpose of article 14;

iv) the appellants' status as persons suffering from mental disorder, or as a mental patient or as a detained mental patient does not constitute a 'personal characteristic' such as to give them an 'other status' for the purposes of article 14; and any interference with article 8 rights, whether considered alone or together with article 14 was justified.

As already stated, the appellants further say that the Exemption Regulations are irrational and contrary to the common law principle of equality in so far as they proscribe smoking in mental health units while permitting it to continue in other residential public spaces such as prisons and care homes. This point is taken only against the Secretary of State.

28. As we see it, the case against the Trust depends upon the relevant appellant succeeding on both the issues under article 8. The Trust accepts that it is a public authority within section 6(1) of the HRA. The question is whether the Trust's policy infringed the appellants' rights under article 8 when the policy was introduced on 1 April 2007 and/or until 1 July 2008. If it did not, it cannot otherwise be liable to the appellants. They cannot enlist the support of article 14 against the Trust: it cannot be said that the Trust discriminated against the appellants because of any discrimination between prisoners and detained mental patients. As to the position after 1 July 2008, no exemption for detained mental patients is lawful because of the expiry of the temporary exemption for mental health units on that date under regulation 10(3) of the Exemption Regulations. We note in this regard that the appellants do not say in this appeal that the Exemption Regulations can be read down under section 3 of the HRA in order to nullify regulation 10(3).

29. Two questions potentially arise under article 8, namely whether (in the familiar language) article 8(1) is engaged and, if so, whether the Trust or the Secretary of State has a defence under article 8(2).

**Is article 8(1) engaged?**

30. The first question which it is necessary to answer is whether article 8 confers a right on patients detained in Rampton to smoke without arbitrary interference. We pose the issue in that way because the answer is likely, as the Divisional Court recognised at [105], to dictate the conclusion to the issues arising under article 14. If article 8 does confer such a right, there can be no dispute but that the right was in principle infringed, and the only question will be justification under article 8(2). If it does not confer such a right, it is difficult to see how the question whether the right to smoke falls within the ambit or scope of article 8, and thereby engages article 14, is any different from the first question. The first question can only be answered in the negative if smoking at Rampton falls outwith the scope of the protection of article 8 or Rampton is not to be regarded as a detained patient's home within the meaning of article 8. So the first question is, in reality, a question of scope.

31. The appellants' argument starts with the proposition that article 8(1) protects a person from interference by the state with that which he chooses to do within the privacy of his own home. If that is right, they contend that their life, detained in a hospital like Rampton, can be equated to life at home.

32. The appellants' argument has the merit of simplicity and clarity. If their proposition is correct, they need to do no more than establish that Rampton is their home, and leave the respondents to justify the undoubted interference, if they can. They avoid the difficult, if not faintly ridiculous, task of determining the quality of the activity in question and the part it plays in establishing personal identity or personal development, a task more sensibly to be imposed on a philosopher or politician than a judge. The Divisional Court recalled the different ways courts have described the concept of respect for private life and home life. The cases show that the concept of private life and home life requires respect for 'physical and psychological development', 'personal development and autonomy' (*Pretty*), 'physical and moral integrity (*Raninen*), 'mental stability', 'integrity of a person's identity' (*Razgar*) and 'protection of private sphere and private space' (*Countryside Alliance*). The references are to *Pretty v United Kingdom* (2002) 345 EHRR 1, *Raninen v Finland* (1997) 26 EHRR 563, *R (Razgar) v Secretary of State for the Home Department* [2004] UKHL 27, [2004] 2 AC 368 and *R (Countryside Alliance) v Attorney General* [2007] UKHL 52, [2008] 1 AC 719. See the judgment of the Divisional Court at [99].

33. How is a court to decide whether any particular activity is an aspect of a person's physical or moral integrity or is integral to a person's identity? What is the width of the concept of personal autonomy, if it is not everything a person may wish to do in the privacy of their own home? It is these difficulties which demonstrate, if we may say so with respect, the merits of Lord Rodger's approach in *Countryside Alliance*. Drawing on *Von Hannover v Germany* (2004) 40 EHRR 1, Lord Rodger at [97] to [108] interpreted article 8 as protecting from arbitrary interference many activities which a person chooses to pursue in his private life for enjoyment, and excluded hunting from protection only because it was a public spectacle. If article 8 can be interpreted as conferring a right to do whatever a person chooses to do within the privacy of his own home, subject only to such interference as the state can justify, the law would certainly have the merit of greater simplicity than that hitherto displayed in the jurisprudence as to its scope. In cases where a person pursues an activity within the privacy of his own home, or a place to be regarded as his home, there would be no need to consider whether the activity in question was to be regarded as an important aspect of a person's identity, of their personal sphere or of their personal development.

34. The difficulty with the appellants' first proposition stems from the need to challenge the view that article 8 does not protect everything a person chooses to do at home, coupled with the problem that there is no binding authority on the point. The Divisional Court's conclusions were founded in part on Baroness Hale's acceptance of the proposition at [111] to [116]. Central to her decision is the proposition that the freedom protected by article 8 is not the same as the freedom to do whatever a person chooses to do, even in a private space; see the passage cited by the Divisional Court at [70]:-

> "Article 8 protects the private space, both physical and psychological, within which individuals can develop and relate to others around them. But that falls some way short of protecting everything they might want to do even in that private space…."

35. The basis upon which Baroness Hale distinguishes those freedoms which are protected and those which are not is important in the instant appeal. Under the common law a person may do as he pleases, unless prevented by the law: see her speech [112]. Unlike the common law, the Convention confers rights: [113]. Through the medium of the HRA a democratically elected Parliament may be inhibited from doing what it wills but only in relation to rights which are recognised as fundamental: [114].

36. We must, however, recall that *Countryside Alliance* was not concerned with a solitary activity carried out within the privacy of a person's home. It cannot therefore be deployed as authority on the question whether the right to do anything a person chooses to do within the home is protected from arbitrary interference.

37. The case is however of importance to the approach which this court should adopt. The majority, following the jurisprudence in Strasbourg, demonstrate that the question whether article 8 affords protection to pursuit of the activity in question requires consideration of a number of different factors. None will be dispositive, but their relative importance will vary from case to case. The majority did not adopt the approach of Lord Rodger: see Lord Bingham at [10-15], Baroness Hale at [115-116] and Lord Brown at [139], although Lord Brown expressed dissatisfaction that article 8 did not protect all leisure time pursuits, in the exercise of self-fulfilment. Keene LJ's approach to personal autonomy is to include within the protection afforded by article 8 anything which anybody may value as important, provided it is conducted in private (see [100]). As he acknowledges, that entails reading *Countryside Alliance* as deciding that the claimants only lost because hunting is conducted in public. The passages to which we refer, in our view demonstrate that that is not a permissible reading of the decision of the majority. If the only reason that the claimants lost was the public nature of their activity, their Lordships would have said so. We do not think, therefore, that the issue as to the scope of article 8 can or should be answered by considering simply whether smoking is an activity integral to a person's identity, or is an aspect of social interaction or whether Rampton is to be regarded as a patient's home within the meaning of article 8. Rather, a conclusion can only be reached by consideration of all those factors.

38. The speeches of the majority in *Countryside Alliance* teach that the question whether the activity is carried on in public or private is not determinative in every case. In some cases the nature of the place in which the activity is carried out will be irrelevant: see eg *Pretty* and *Brüggemann and Scheuten v Germany* (1981) 3 EHRR 244 (termination of pregnancy). In others it will be of considerable importance: see eg *Niemietz v Germany* (1993) 16 EHRR 97 at [30].

39. Since the question cannot be answered simply by focusing on the nature of the activity we start by considering the nature of the place in which the appellants seek freedom to smoke. The Trust has accepted that Rampton is the appellants' home. Patients are detained there and have nowhere else in which to conduct their personal affairs or develop as human beings.

40. But Rampton is not the same as a private home and the distinction is of significance. It is a public institution, operated as a hospital under section 4 of the 2006 Act. Supervision is intense for safety and security reasons. All high-risk and newly-admitted patients are subject to a high degree of observation at all times. Regular

checks are made on all occupants. A patient is allowed time in communal areas of the hospital with other patients only with close observation and after a detailed risk assessment: see the Secretary of State's submissions cited at [75] of the judgment of Divisional Court.

41. The degree to which a person may expect freedom to do as he pleases and engage in personal and private activity will vary according to the nature of the accommodation in which he lives; see [102] of the judgment of the Divisional Court. If one assumes for the purposes of argument, that Baroness Hale is wrong and that any activity within a private home is protected from arbitrary interference, it does not follow that the same activities within a public hospital where patients are detained are similarly protected.

42. Article 8 seeks to prevent intrusion by the state into the physical and private space which the concept of home represents. For example, what one eats or drinks may not be important, but that the state should dictate what a person eats or drinks in the privacy of a person's own home would be regarded as deeply intrusive. As Isaiah Berlin put it:

> "The desire not to be impinged upon, to be left to oneself, has been a mark of high civilization both on the part of individuals and communities. The sense of privacy itself, of the area of personal relationships as something sacred in its own right, derives from a conception of freedom which for all its religious roots, is scarcely older, in its developed state, than the Renaissance or Reformation. Yet its decline would mark the death of a civilization, of an entire moral outlook." (Inaugural Lecture, Oxford 1958)

43. The ECtHR emphasised in *Niemitz* that the concept of private life under article 8 embraced social interaction. But it recognised that the starting point was protection of a person's "inner circle" in which the individual may live his own personal life as he chooses, free from intrusion by the outside world. The ECtHR said at [29],:

> "The Court does not consider it possible or necessary to attempt an exhaustive definition of the notion of 'private life.' However, it would be too restrictive to limit the notion to an 'inner circle' in which the individual may live his own personal life as he chooses and to exclude therefrom entirely the outside world not encompassed within that circle. Respect for private life must also comprise to a certain degree the right to establish and develop relationships with other human beings."

44. Any intrusion within that inner circle is offensive. It is the fact of intrusion into the home which offends, irrespective of the importance of the activity which an individual seeks to pursue within the home. But that inner circle, whilst not destroyed, is significantly penetrated by reason of the very fact that a person is confined within a secure hospital. The patient does not lose all right to a private life but the nature of that life and the activities which he may pursue are seriously restricted and always overlooked. No patient can choose freely what he eats or drinks. That is not simply because restrictions can be justified, but more

fundamentally because of the nature of the institution in which he eats and drinks. Even if, *pace* Baroness Hale, a person may do as he pleases in his own home, no-one can expect such freedom when detained in a secure hospital. It is not a place in which, as Lord Hope puts it in *Countryside Alliance* at [54], he can expect quiet enjoyment. It is a public not a private place, even though we accept that a detained patient's private life has not been and must not be eroded completely.

45. It is in that context that we must consider the nature of the activity in question. The Trust suggested that smoking was a leisure time activity of choice, not unlike hunting. However, we have some difficulty with that suggestion, since although it might start as an activity of choice, it soon becomes an addiction, which many find difficult to escape, possibly ignorant of research which shows that it requires only six weeks to break free. The Divisional Court concluded at [101] that the activity was not an aspect of a person's physical or moral integrity. Nor did it fall within other descriptions of the concepts in article 8. Any conclusion which depends on a court's assessment of the importance of a particular activity is open to substantial dispute. As we have indicated, there is no judicial process by which that can be judged, since it will be invariably a matter of individual taste or fanaticism. *Bensaid v United Kingdom* (2001) 33 EHRR 10 teaches :

> "[46] Not every act or measure which adversely affects moral or physical integrity will interfere with the right to respect to private life guaranteed by Article 8. However, the Court's case-law does not exclude that treatment which does not reach the severity of Article 3 treatment may nonetheless breach Article 8 in its private-life aspect where there are sufficiently adverse effects on physical and moral integrity.
>
> [47] "Private life" is a broad term not susceptible to exhaustive definition. The Court has already held that elements such as gender identification, name and sexual orientation and sexual life are important elements of the personal sphere protected by Article 8. … Mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity. Article 8 protects a right to identity and personal development, and the right to establish and develop relationships with other human beings and the outside world … The preservation of mental stability is in that context an indispensable precondition to effective enjoyment of the right to respect for private life."

46. But how can any court determine whether smoking is an important element of the personal sphere protected by article 8 or a crucial part of private life? As the Divisional Court remarked, the concept of personal autonomy, which the ECtHR adopted in *Pretty*, is wide enough to incorporate a right to choose to smoke. This is the approach of Keene LJ. We suggest, however, what is important is not the addiction, which he describes at [100] as a pastime or as essential fuel to creativity, but, rather, freedom from interference by the state. As we have sought to emphasise, that freedom is already significantly constricted within the confines of a secure hospital. There is no basis for distinguishing the loss of freedom to choose what one eats or drinks in such an institution and the ban on smoking. Article 8 does apply to

closed institutions, as Keene LJ says [103] but to a far more limited extent than it would to activities in a person's home. Moreover, it was suggested on behalf of the appellants that the smoking ban made their lives intolerable. There is certainly evidence that concerns were expressed before the change of policy that detainees might find it difficult to come to terms with the change but, as noted by the Divisional Court in [39] which is quoted in Appendix A, none of the disturbing consequences feared by the claimants has occurred.

47. Nor do we think we should express any view as to whether smoking is desirable or undesirable, sensible or foolish, rational or irrational. We entirely accept that the principle of autonomy must include the right to act in a way that is or may be considered undesirable, foolish or irrational: see e.g. *Re MB (Medical Treatment)* [1997] 2 FLR 426 per Butler-Sloss LJ at 432G.

48. Adopting the approach of Lord Bingham, no analogy can be drawn with any of the decided cases. The most that can be said is, to echo the words of Lord Hope, that the case is not about the kind of choice which Mrs Pretty was forced to make "about her own body or physical identity". Nor can it be equated with what Lord Bingham described as the very personal and private concern relating to abortion in *Brüggemann*.

49. Since the nature of the place in which the appellants seek to smoke tells against any right protected by article 8, those seeking protection are compelled to rely to a greater extent on the importance of the activity they seek freedom to pursue. The less the appellant can rely upon the nature of the place in which the activity is pursued, the more he must rely upon the proximity of the activity to his personal identity or physical and moral integrity. Of course we accept that every activity a detained patient is free to pursue is all the more precious in a place where so many ordinary activities are precluded. But that does not mean that we must abandon the concept of private life which previous jurisprudence has sought to explain. Difficult as it is to judge the importance of smoking to the integrity of a person's identity, it is not, in our view sufficiently close to qualify as an activity meriting the protection of article 8. It is some distance away from the examples considered in Lord Bingham's speech in *Countryside Alliance* and it is certainly not to be equated with development of a patient's personality, as Lord Rodger understood that concept at [107].

50. We reject the argument that the right to smoke was an aspect of the "right to establish and develop relationships with other human beings and the outside world", which Lord Hope placed " to a certain degree", within the scope of the protection of article 8, citing *Niemitz* at [29]. We accept the submission made by Mr Lock on behalf of the Trust that, although there is some evidence that smoking in a hospital like Rampton had some elements of social interaction, it was very limited because it could only take place in small smoking rooms with few if any others being present at the same time.

51. We conclude, in agreement with the Divisional Court, that article 8 does not protect a right to smoke in Rampton. The prohibition does not, in such an institution, have a sufficiently adverse effect on a patient's physical or moral integrity

52. It follows that the appeal or appeals against the Trust must fail, that its policy is lawful and that the appeals against the Secretary of State must fail in so far as they

depend upon article 8 standing alone. It also follows that the issue of justification under article 8(2) does not arise but, since it was argued in some detail, we will shortly consider it. However, although the considerations relevant to justification under article 8(2) are different in the case of the Trust on the one hand and the Secretary of State on the other and are also different under article 8(2) standing alone and in association with article 14, there is an overlap between them and it is convenient to consider them together. But we should consider first whether article 14 is engaged at all.

**Article 14**

53. The appellants say that, even if article 8(1) standing alone is not engaged, smoking comes within the ambit of the article and the appellants are thereby entitled to rely on article 14 to protect them from the discriminatory nature of the restrictions on smoking. However, we have already expressed the view that, at any rate in the context of article 8 in the present case, if the right to smoke does not come within the ambit or scope of article 8 standing alone, it cannot come within the ambit or scope of article 8 for the purposes of article 14. It follows that it is not fruitful for us to discuss the different approaches to 'ambit' and 'scope' in some of the authorities.

54. It follows that the appellants must fail and the appeals be dismissed whether the claims are put under article 8 alone or in conjunction with article 14. It further follows that the question whether the appellants have an 'other status' within the meaning of article 14 does not arise. We therefore refer to it only very briefly.

**'Other status'**

55. It is not suggested that there was discrimination on any ground except 'other status'. The Divisional Court tentatively expressed the view that the appellants did not have 'other status' within the meaning of article 14 for the reasons given at [106] to [109]. The 'other status' considered by the Divisional Court was that contended for by the appellants at that time, namely that of being detained patients in a high security mental hospital. Reference was made to *Clift*, where it was held, albeit by a close margin, that Clift's classification as a prisoner serving a determinate sentence of 15 years or more did not give him a relevant 'status': see the judgment of the Divisional Court at [106].

56. In *Clift* Lord Bingham had quoted [56] from the decision of the ECtHR in *Kjeldsen, Busk Madsen and Pedersen v Denmark* (1976) 1 EHRR 711:

> "Article 14 prohibits, within the ambit of the rights and freedoms guaranteed, discriminatory treatment having as its basis or reason a personal characteristic ('status') by which persons or groups of persons are distinguishable from each other."

At [107] the Divisional Court noted that regulation 10 covers all mental health units and not just the likes of Rampton. It concluded at [107]:

> "We would not consider that mental illness itself confers a status, within the meaning of article 14, and any narrower

> definition of the status claimed for the claimants presents further problems of definition, whether the status is that of mental patient in hospital or mental patient detained in hospital. We are inclined to the view that the status claimed is not a "personal characteristic" (*Kjeldsen*) contemplated by article 14, especially when considered alongside the categories of status specified in article 14."

It may be observed that the Divisional Court expressed only a provisional view on the 'other status' point

57. The points made by the Divisional Court at [108] and [109] do not seem to us to be relevant to the 'other status' point. In any event, the position is now somewhat different from that before the Divisional Court. There have been two decisions of the House of Lords in this area of some importance, namely *R (RJM) v Secretary of State for Work and Pensions* [2008] UKHL 63, [2008] 3 WLR 1023 and *AL (Serbia) v Secretary of State for the Home Department* [2008] UKHL 42, [2008] 1 WLR 1434, which perhaps support a broader approach than hitherto and thus a broader approach than that adopted by the Divisional Court. *RJM* supports a broader approach to 'other status' and so, perhaps does *Shelley v United Kingdom* (2008) 46 EHRR SE 16. However, quite apart from 'other status' viewed discretely, it is at least arguable that, as submitted by Mr Bowen, the focus of the inquiry should be on the broad question whether the differences in similar situations justify a different treatment, the 'status' of the person being simply a relevant factor in deciding whether the difference is or is not justified. See eg *RJM* per Lord Neuberger at [40] and *AL (Serbia)* per Baroness Hale (with whom the other members of the appellate committee agreed) at [24], [25] and [28].

58. Baroness Hale said this:

> "24. It will be noted, however, that the classic Strasbourg statements of the law do not place any emphasis on the identification of an exact comparator. They ask whether "differences in otherwise similar situations justify a different treatment". …
>
> 25. … in only a handful of cases has the Court found that the persons with whom the complainant wishes to compare himself are not in a relevantly similar or analogous position (around 4.5%). This bears out the observation of Professor David Feldman, in *Civil Liberties and Human Rights in England and Wales*, 2nd ed (2002), p 144, quoted by Lord Walker in [*R (Carson) v Secretary of State for Work and Pensions* [2005] UKHL 37, [2006] 1 AC 173] at para 65:
>
>> "The way the court approaches it is not to look for identity of position between different cases, but to ask whether the applicant and the people who are treated differently are in 'analogous' situations. This will to some extent depend on whether there is an objective and reasonable

> justification for the difference in treatment, which overlaps with the questions about the acceptability of the ground and the justifiability of the difference in treatment. This is why, as van Dijk and van Hoof observe, … 'in most instances of the Strasbourg case law . . . the comparability test is glossed over, and the emphasis is (almost) completely on the justification test'.

…. This suggests that, unless there are very obvious relevant differences between the two situations, it is better to concentrate on the reasons for the difference in treatment and whether they amount to an objective and reasonable justification.

…

28. I say all this because so much argument has been devoted in this case, and in too many others, to identifying the precise characteristics of the persons with whom these two young men should be compared. This is an arid exercise. …"

59. That approach seems to us to be the approach most favourable to the appellants and for the purposes of this appeal we will assume that it is correct. We note in passing that the appellants' case under this head is supported by the Equality and Human Rights Commission. The appellants' case is that the discrimination between prisoners who are permitted to smoke on the one hand and detainees in Rampton who are not permitted to smoke on the other hand is unlawful by reason of article 14 unless it can be justified by the Secretary of State. In these circumstances we turn to justification.

**Justification – article 8**

60. The first question under this head is whether, assuming (contrary to our view) that the smoking ban introduced by the Trust in principle engages the appellants' rights under article 8(1), the Trust can justify its policy under article 8(2). In short the question is whether the policy was in accordance with the law and "necessary in a democratic society … for the protection of health … or for the protection of the rights and freedoms of others".

61. There can be no issue but that the policy is in accordance with the law. When it was introduced there was no statute or other legal instrument or principle preventing the Trust from banning smoking. The Trust owns and operates Rampton (and other hospitals in its area) and, subject to duties owed to patients or staff, it can set the rules for the operation of the site. As Lord Bingham put it in *Kay v Lambeth London Borough Council* [2006] UKHL 10, [2006] 2 AC 465, at [36]:

"The public authority owner or landlord has, broadly speaking, a right to manage and control its property within bounds set by statute."

62. The Trust owes duties both to its staff and to its patients. We will focus on its duties in the case of Rampton, although it of course owes duties to its staff and patients in many other hospitals. The fact that patients at Rampton are in compulsory detention under the MHA makes its relationship with its patients very different from its relationship with other patients who might wish to smoke. The Trust exists to deliver health care to its patients in Rampton in a secure and clinically appropriate environment. It owes a duty of care to them which covers both their physical and their psychological health and which includes a duty to take reasonable steps to prevent patients from causing themselves self harm. Thus paragraph 30 of the Safety and Security in Ashworth, Broadmoor and Rampton Hospitals Directions 2000 requires the Trust to assess each patient against a range of factors including "whether the patient presents a high risk of … (b) committing suicide or self harming". That involves preventing patients, whether they have legal capacity or not, from taking action which, if they were not in detention, would be lawful: see eg *Reeves v Commissioner of the Metropolitan Police* [2000] 1 AC 360, per Lord Hope at page 379. It includes preventing patients from having access to materials they can use to harm themselves. This duty arises at common law but is also supported by the Code of Practice issued under section 118 of the MHA.

63. Patients detained in Rampton are subject to a large number of restrictions which prevent them from doing things which they can do at home, in a care home, at a hotel or (in some respects) in prison. They include restriction on free movement, sexual relations, drinking alcohol, access to explicit pornographic material, contact within Rampton and externally, relationships with others, food and other items being sent or brought into the hospital and keeping possessions. Patients are also subject to random and routine searches, examination of correspondence and testing for illicit substances.

64. In 2004 the Health Development Agency, which is part of the NHS, issued a report entitled "Smoking and patients with mental health problems", which described the background as follows:

- Smoking rates are much higher among people with health problems than among the general population.

- Smoking has a serious impact on the physical and financial wellbeing of smokers with mental health problems.

- Many smokers with mental health problems want to stop smoking but do not receive the advice and support they need to do so.

- Good evidence exists that smokers with mental health problems can be helped to stop smoking.

The report recommended various steps to be taken, the last of which was:

> "All mental health trusts should introduce smoke free policies as soon as possible."

65. The Trust accepted that the imposition of a smoke free policy was a further restriction on the activities of patients, albeit one which was, as counsel put it, massively to the benefit of their health. Although it was accepted that the policy was against the

wishes of some patients, it has long term health benefits for both patients and staff. We accept the Trust's submission that it may be necessary to take long term decisions for the benefit of patients and staff even though to do so would cause short term problems, provided that careful management was employed in their implementation. Although there were predictions of dire consequences if a ban was introduced, and although it was suggested that there were dangers to the mental health of patients and risks of an increased level of aggression on the wards, the King's Fund Report of July 2006 predicted that this would not happen. In the event, as stated above, it has not happened.

66. As already indicated, the Trust owes a duty of care to its staff. It identified a risk to its staff from SHS, from which it follows that it had a duty to take all reasonable precautions to protect staff from that risk. The Trust submits that in all these circumstances and in the light of the material in Appendix A and the other evidence before the court, it was necessary and proportionate for the protection of the health of both patients and staff to introduce the policy of banning smoking, subject to very limited exceptions.

67. Mr Bowen did not challenge the lawfulness of the Trust's action in generally preventing smoking by patients outside the buildings (save in those cases where an exemption had been granted to a patient in accordance with the policy described at paragraph 16 above) but he submitted that a proportionate measure would have been to continue to permit smoking inside. He submitted that a fair balance must be struck between the legitimate aim of the Trust's policy and the interests of the individual concerned. At [114] the Divisional Court directed itself by reference to the principles stated by Lord Clyde in *de Freitas v Permanent Secretary of the Ministry of Agriculture* [1999] AC 69 at 80F-G. It accordingly asked itself (i) whether the legislative objective was sufficiently important to justify limiting a fundamental right, (ii) whether the measures designed to meet the legislative objective were rationally connected to it; and (iii) whether the means used to impair the right or freedom were no more than was necessary to accomplish the objective. In the case of the Trust the Divisional Court asked itself those questions with regard to the policy of the Trust and, in the case of the Secretary of State, it asked them in relation to regulation 10(3) of the Exemption Regulations, which of course provided for the exemption for mental health units to cease to have effect in July 2008.

68. The Divisional Court answered all three questions in the affirmative, both as regards the Trust and as regards the Secretary of State: see [115] to [116], [117] and [118] to [130] respectively. In particular at [119] the Divisional Court noted that Mr Bowen relied upon the Ministerial Statement set out at [20] of the judgment which is quoted in Appendix A. In particular Mr Bowen relied upon the statement that the Government was taking the power to make the limited exemptions, not only because it believed that it was right in principle, but also to fulfil their obligations under the Human Rights Act 1998 on respect for private life. He submitted that in those circumstances it was disproportionate to introduce a total ban in mental health units, which was the unintended consequence of regulation 10(3).

69. The Divisional Court held that both the policy and the removal of the exemption were proportionate and justified, essentially for these reasons:

i) There is strong evidence of the dangers of smoking both to smokers and to those subject to SHS and powerful evidence that in the interests of public health a complete ban was justified in appropriate circumstances: see [125].

ii) Substantial health benefits arose from the ban and, as experience has shown, the disbenefits were insubstantial. Both health and security considerations justify the ban even though smoking in the grounds is not feasible at Rampton. See [126] and [127].

iii) Security requirements were relevant and supported the case that the ban at Rampton was proportionate: see [128].

iv) The Exemption Regulations were introduced following an intensive consultation exercise and the courts should respect "the recent and closely considered judgment of a democratic assembly": *Countryside Alliance* per Lord Bingham at [47], Lord Hope at [89] and Baroness Hale at [127]. The margin of appreciation in relation to social policy should be a wide one: *James v United Kingdom* (!966) 8 EHRR 123. See also *Hatton v United Kingdom* (2003) 37 EHRR 611 at [97]. See the judgment of the Divisional Court at [129] and [130].

70. Both respondents submitted that the Divisional Court was right for the reasons it gave. The Trust stressed that its reasoning was supported by the 2005 Guidance from the Health Development Agency:

> "The smokefree policy should be seen in the same light as policies on alcohol and illicit drugs. Those addicted to alcohol and illicit drugs are not allowed to bring them on to hospital premises but are instead offered treatment for their addictions."

The Trust submitted that it was reasonable for it to approach smoking in the same way as other types of self harm which, like smoking, would be lawful outside Rampton. We accept that submission.

71. In our judgment the Trust was entitled to introduce the smoking ban at Rampton, essentially for the reasons it has given. As the Trust observed, article 8(2) refers to the protection of health, not the health of others. In these circumstances we accept the submission that it is a potentially legitimate aim to restrain a person's article 8 rights for the protection of health. It was necessary and proportionate for the health of both the patients, which of course includes the appellants, and others. We do not think that there is any real distinction between banning alcohol and banning smoking in Rampton.

72. In short we agree with the conclusions of the Divisional Court that there is strong evidence of the dangers of smoking both to smokers and to those subject to SHS and powerful evidence that in the interests of public health a complete ban was justified in appropriate circumstances. We further agree that substantial health benefits arose from the ban and, as experience has shown, that the disbenefits were insubstantial. As to SHS, there has emerged powerful evidence of its dangers which supports the Trust's case on justification in a way which might not have been the case in the past.

In all these circumstances we agree that the Trust's policy would be justified under article 8(2) if article 8 were engaged at all.

73. As to the position of the Secretary of State, the position is much the same in so far as the risks of smoking and the risks of SHS are concerned. The smoke free legislation has the effect that since 1 July 2008 smoking is only allowed in parts of mental health units which are not enclosed or substantially enclosed. It appears to us that the considerations that lead to the conclusion that the Trust's policy is justifiable also lead to the conclusion that the Exemption Regulations, including regulation 10(3) are also justifiable.

74. That conclusion is reinforced by the considerations derived from the judgment of the Divisional Court in paragraph 69(iv) above. They are that the Exemption Regulations were introduced following an intensive consultation exercise, that the courts should respect "the recent and closely considered judgment of a democratic assembly" and that the margin of appreciation in relation to social policy should be a wide one. Although the doctrine of margin of appreciation is applicable to the approach of the ECtHR rather than to the approach of the national courts to national legislation, the principle of respect for such legislation is very similar. We accept the submissions of the Secretary of State that these principles apply here in the context of legislation which represents a considered democratic compromise following an extensive consultation in order to protect both the health of the patient and the health of those who might otherwise be exposed to SHS. As the Divisional Court put it at [130], the 2007 Regulations were enacted following an intensive consultation exercise and intense parliamentary scrutiny through the affirmative parliamentary procedure and scrutiny by the Joint Committee on Statutory Instruments.

75. We do not accept the submission made on behalf of the appellants that there cannot have been any balancing of the relevant considerations because the unintended consequence of the legislation was that there is a blanket ban in some mental health units. The question whether the ban is justified must be tested as at the time it is attacked: see eg *RJM* per Lord Neuberger at [52]. In any event the prohibition on smoking outside is not the consequence of the legislation, because it permits smoking outside, but of the Trust's policy. Moreover, we accept the submission that it would have been clear to the Secretary of State and Parliament that, if a person could not go outside to smoke, the smoke free legislation might have the effect of prohibiting him from smoking at all. This might be true of a long term patient in an ordinary NHS hospital who because of his illness or injuries could not go outside. The Secretary of State concluded after a period of consultation, contrary to the view held earlier, that there was good reason for a time limited exemption for mental health units which should not be indefinite. That view was accepted by Parliament when the Exemption Regulations were approved by positive resolution of both Houses and it is a view which should be respected by the courts.

76. For these reasons we agree with the Divisional Court that, if article 8 was engaged the Secretary of State has successfully justified the legislation under article 8(2).

**Justification – article 14**

77. The approach to justification is similar if (contrary to our view) the appellants' case is within the scope or ambit of article 8 and there is discrimination on an article 14

ground. If there is such discrimination, it is, as we see it, by reason of the difference in treatment between those in mental health units like Rampton and those in prison. The correct approach to justification in such a case is to consider it in as "simple and non-technical" a way as possible: see eg *Carson* per Lord Nicholls at [2] to [3], per Lord Hoffmann at [28] to [33] and per Lord Walker at [64] to [68] and *AL (Serbia)* per Baroness Hale at [24] to [31].

78. In this regard we accept the submissions made on behalf of the Secretary of State. First, the alleged ground of discrimination is not one that calls for severe scrutiny. The more peripheral or debateable the suggested characteristic is, the easier it is to justify: *RJM* per Lord Walker at [5]. The ground relied upon, namely being a patient in a mental health unit is not a 'suspect' one in the sense used by Richards LJ in *R (Wilson) v Wychavon District Council* [2007] EWCA Civ 52 at [46] to [55]. Decisions about the general public interest which underpin differences in treatment on grounds within the non-suspect category are "very much a matter for the democratically elected branches of government": see *Carson* per Lord Hoffmann at [16] and per Lord Walker at [55] to [60]. See also per Lord Neuberger in *RJM* at [56].

79. Second, in this context

> "the drawing of lines which create distinctions is peculiarly a legislative task and an unavoidable one. Perfection in making the necessary classifications is neither possible nor necessary"; such demarcation lines "have to be reasonably bright".

See *Carson* per Lord Walker at [56], *AL (Serbia)* per Baroness Hale at [44] and *RJM* per Lord Neuberger at [54].

80. Third, for the reasons given above, having regard to the fact that the differential treatment is the result of a recent and considered judgment by the legislature after extensive consultation, the area of discretion to be left to the legislature, and to the Secretary of State, is a wide one. In particular, it is the 2006 Act which prohibits smoking indoors and Parliament entrusted the Secretary of State with a limited power to make exemptions. The Secretary of State exercised that power in accordance with the will of Parliament and having regard to the recommendations of the cross-party Health Select Committee of the House of Commons. Moreover, the Exemption Regulations were approved by both Houses of Parliament by affirmative resolution and scrutinised by the Joint Committee on Statutory Instruments.

81. Fourth, the findings of the Divisional Court in this regard as to the relevant public documents and evidence are at Appendix A below. They show that there was considerable support for the change of view on the part of the Secretary of State from the desirability of a total exemption for patients in hospitals like Rampton to the desirability of a time limited exemption after which such hospitals must be smoke free: see [24] to [29] and [38] quoted in Appendix A. A balance had to be struck between the risk to the patients of smoking and the risks to others of SHS on the one hand and the possible benefits to and the wishes of many patients on the other. In our judgment the decision of the Secretary of State approved by Parliament was rational, legitimate and justifiable.

82. Fifth, there is in our view a legitimate basis for distinguishing between those in, say, Rampton on the one hand and those in prison on the other. In particular those in Rampton are patients entrusted to the care of the NHS for their own benefit and for the security both of the public and of themselves. Unlike prisons, the facilities are staffed by doctors and nurses, whose prime focus is on the health care of the patient. The only respect in which they may be comparable is that in both institutions persons are detained by compulsion of law. On the other hand, prisons did not fall within the Government's commitment to create a smoke free NHS. Mental health units and prisons provide very different services.

83. Sixth, the Secretary of State was concerned that an indefinite exemption for mental health units would discriminate against NHS patients in mental health units by treating them differently from other NHS patients and so exacerbate existing health inequalities. That concern stemmed from the fact that mental health units are part of the NHS and treat NHS patients. That does not apply to prisons, which did not fall within the Government's commitment to create a smoke free NHS. Moreover, as appears above, there was evidence and research demonstrating the feasibility of making mental health units smoke free, whereas there was no evidence or research to the same effect in the case of prisons. On the contrary, there was some evidence that applying the smoke free provisions to prisons in the short term would increase the risk of disorder and assaults and compliance would be difficult to achieve.

84. Seventh, whereas, as also appears above and from Appendix A, there was substantial evidence from respondents to the consultation that mental health units should and could feasibly be made smoke free within a short period, there was not the same evidence from respondents in respect of prisons. The Secretary of State recognised the desirability of attaining smoke free prisons but did not consider that that objective could be achieved in the short term and decided to provide for an indefinite exemption in respect of prisons. However, the Prison Service has put policies in place that further limit smoking in prisons and aims to attain 100 per cent smoke free prisons in the future.

85. In all these circumstances we conclude that the Secretary of State has successfully justified the difference of treatment between mental health units and prisons. Moreover, we are not persuaded that the Exemption Regulations go beyond what was contemplated in the 2006 Act. They were *intra vires* and were both reasonable and proportionate.

86. We also conclude that the Secretary of State has successfully justified the difference of treatment between mental health units and care homes and hospices. Again, we accept the submissions made on behalf of the Secretary of State. As to care homes:

i) the purpose of an adult care home is to provide a supported home for those who require such support, it is not to provide health care in an NHS environment;

ii) whereas a majority of respondents opposed an indefinite exemption for mental health units, they were equally divided in the case of care homes; and

iii) although the Secretary of State recognised that, as a consequence of the exemption, staff would not be fully protected from SHS, it was decided that, at

any rate for the time being, such an exemption was appropriate in respect of accommodation that is specifically intended to be a home for its residents.

87. As to hospices, the distinctions between mental health units and hospices are also such that they should not be seen as in an analogous position, essentially for these reasons:

i) by contrast with mental health units, the purpose of a hospice is to provide palliative care at the end of life, namely to relieve pain and other symptoms and improve quality of life, especially to those suffering from progressive disease in its final stages;

ii) the respondents to the consultation were about equally divided;

iii) one of the key stakeholders, Help the Hospice, strongly supported the proposed indefinite extension on the ground that, in the case of lifelong smokers, to ban smoking would be contrary to the purpose of a hospice, namely to improve quality of life at the end of life; and

iv) as in the case of care homes, the Secretary of State recognised that staff would not be protected from SHS but concluded that the balance should be struck in favour of allowing smoking in designated rooms by those nearing the end of their lives.

## CONCLUSIONS

88. Our conclusions on the issues in the appeal can be summarised as follows :

i) The right or freedom to smoke does not engage article 8(1) of the Convention.

ii) It follows that the appeals against the Trust must fail and that its policy is lawful.

iii) It also follows that the appeals must fail against the Secretary of State in so far as they rely upon article 8, standing alone.

iv) The right or freedom to freedom to smoke is not within the ambit or scope of article 8 for the purposes of article 14 of the Convention.

v) It follows that the appeals must fail against the Secretary of State in so far as they rely upon article 14.

vi) The remaining issues do not arise but we have concluded that both the Trust the Secretary of State have successfully justified their respective actions under article 8(2) and, on the assumption that there is in principle discrimination within article 14 by the Secretary of State, the Secretary of State has successfully justified the position in the light of differences of treatment between mental health units on the one hand and prisons, care homes and hospices on the other.

**Common law**

89. As indicated earlier the appellants seek permission to appeal against the Secretary of State on the ground that the Exemption Regulations are irrational and contrary to the common law principle of equality in so far as they proscribe smoking in mental health units while permitting it in other residential public spaces such as prisons and care homes.

90. In this regard we accept the submission on behalf of the Secretary of State that the principle of equality referred to by the Privy Council in *Matadeen v Pointu* [1999] 1 AC 98 simply means that distinctions between different groups must be drawn on a rational basis. It is thus no more than an example of the application of *Wednesbury* rationality: see eg per Lord Hoffmann at page 109E-G. See also *R (Association of British Civilian Refugees – Far East Region v Secretary of State for Defence* [2003] QB 1397 per Dyson LJ at [85] and *R v Immigration Appeal Tribunal ex p Manshoora Begum* [1986] Imm AR 385 per Simon Brown J at pages 393-4.

91. In any event for the reasons given in the context of justification we conclude that the Secretary of State was not in breach of any common law principle of equality. In all the circumstances, we do not think that we should grant permission to appeal on this point.

**Lord Justice Keene:**

92. The facts of this case have been fully and clearly set out in the judgment of the Master of the Rolls and Lord Justice Moses ("the majority") and it is unnecessary for me to add to them. I approach the issues arising, however, in a different framework, beginning with the Exemption Regulations themselves rather than with the position of the Trust. Nonetheless, the first issue which clearly calls for determination is whether the activity of smoking falls within the scope of the right to respect for private life, as protected by Article 8(1) of the Convention.

93. At this stage, of course, one is not dealing with whether there has been a breach of Article 8, which requires a further investigation into the interference and any justification put forward for it, but solely with whether Article 8 is engaged. The boundaries of the right to respect for private life are notoriously difficult to define, as the differing views of the members of the Judicial Committee of the House of Lords in the *Countryside Alliance* case illustrate. Indeed, on several occasions the Strasbourg Court has opined that it does not consider it:

> "possible or necessary to attempt an exhaustive definition of the notion of 'private life'."

See (for example) *Niemietz v. Germany* [1993] 16 EHRR 97 at paragraph 29. But in general the Strasbourg Court has taken a generous approach to the meaning of private life. It is of

> "such a scope as to secure to the individual a sphere within which he can freely pursue the development and fulfilment of his personality.": *Brűggemann and Scheuten v. Federal Republic of Germany* [1981] 3 EHRR 244, paragraph 55.

Strasbourg has in fact been at some pains to emphasise that it is a right which extends beyond being entitled to live in the way that one chooses. Thus in *Brűggemann*, the Commission noted that it had held that the concept of private life was broader than the definition given by numerous Anglo-Saxon and French authors, namely, "the right to live as far as one wishes, protected from publicity", because it also encompassed to a certain degree the right to establish and develop relationships with other people: paragraph 57.

94. Amongst the more recent decisions in which the approach of the Strasbourg Court has been spelt out is the case of *Pretty v. United Kingdom* [2002] 35 EHRR 1, where this country's prohibition on assisting suicide was in issue. Although Mrs Pretty lost, the Court found that Article 8 was engaged. Paragraphs 61 and 62 of the judgment are of relevance. At paragraph 61, in dealing with the scope of Article 8, the Court said that:

> "the notion of personal autonomy is an important principle underlying the interpretation of its guarantees."

Paragraph 62 is of importance, because it indicates the interpretation which the Court was applying, namely the ability to conduct one's life in a manner of one's own choosing. The passage reads as follows:

> "The Court would observe that the ability to conduct one's life in a manner of one's own choosing may also include the opportunity to pursue activities perceived to be of a physically or morally harmful or dangerous nature for the individual concerned."

The relevance of that passage to people's pursuit of the activity of smoking is too obvious to need emphasising.

95. Of course, all of this is no more than persuasive material which this court is merely required by section 2(1) of the Human Rights Act 1998 to take into account. But a not dissimilar approach has been taken by the domestic courts. I can confine myself to the most recent pronouncement on this topic by the House of Lords. In the *Countryside Alliance* case, Lord Bingham of Cornhill at paragraph 10 (a paragraph with which Lord Brown of Eaton-under-Heywood expressly agreed – see paragraph 138) said of Article 8:

> "But the purpose of the article is in my view clear. It is to protect the individual against intrusion by agents of the state, unless for good reason, into *the private sphere within which individuals expect to be left alone to conduct their personal affairs and live their personal lives as they choose.*" (emphasis added)

Lord Bingham rejected the argument that fox-hunting could be brought within the scope of such personal autonomy, because it

> "is a very public activity, carried out in daylight with considerable colour and noise, often attracting the attention of on-lookers attracted by the spectacle": paragraph 15(1).

96. Lord Hope of Craighead seems to have come to much the same conclusion at paragraph 55, without attempting a detailed analysis of the right to private life itself. Lord Rodger of Earlsferry emphasised the way the Strasbourg Court had approached the meaning of Article 8(1) in the *Pretty* case, referring to the notion of "personal autonomy" contained in the passage from paragraph 61 which I have quoted earlier. He went on to instance various activities which individuals might regard as "integral to their identity" or a "core part" of their lives, such as singing or playing a musical instrument, but he also observed, by reference to *Von Hannover v. Germany* [2004] 40 EHRR 1, that confining the protection of article 8(1) to those for whom an activity is a core part of their lives "may be to set the bar too high": paragraph 102. If publishing photographs of Princess Caroline riding a bicycle or going to the market engaged Article 8, then (he said) surely it would be engaged by a ban on her doing any of these things: paragraph 105. It was again only because hunting was a public spectacle that Lord Rodger concluded that Article 8(1) did not apply.

97. Lord Brown of Eaton-under-Heywood regarded, as I have said, Lord Bingham's analysis as correct, but added that he would wish to see the scope of Article 8 enlarged further by the Strasbourg Court, to encompass "a broad philosophy of live and let live": paragraph 139. The more restrictive analysis came from Baroness Hale, whose view was that something more than a freedom to do as one pleases was required for protection by Article 8. She recognised the importance of personal and psychological space within which each individual develops his or her own sense of self and relationships with other people, but then added:

> "This is fundamentally what families are for and why democracies value family life so highly": paragraph 115."

98. Where does an analysis of those views get one in identifying, as best one can, the proper scope of Article 8? I accept that the rights under the Convention are not intended to protect trivial aspects of day-to-day life. There has to be a degree of significance and value to an individual or group of individuals about an activity before it can qualify for protection so as to engage Article 8. But once one has reached that level, the concept of personal autonomy seems to me to be recognised by the House of Lords to be a broad one and, moreover, one which is morally neutral, in the sense described by the Strasbourg Court in *Pretty*. An activity need not be one of which the court approves to fall within the scope of the article:

> "Dost thou think, because thou art virtuous, there shall be no more cakes and ale": (*Twelfth Night*, Act II, Scene 3, per Sir Toby Belch).

99. What is meant by personal autonomy is, in Lord Bingham's words, the ability to conduct one's personal life and affairs as one chooses. It may well be that in many cases this will involve, as Baroness Hale noted, family relationships, but that cannot properly be seen as a necessary requirement, since there are literally millions of adults in this country (quite apart from those in other Convention countries) who live on their own and not in a family context. Their activities are entitled to the protection offered by Article 8.

100. To a non-smoker like myself the importance of the activity of smoking to someone who smokes regularly or who may have smoked for many years is not easy to gauge,

but it is apparent that to such people it is a pastime greatly valued. One knows of writers and journalists who cannot write without smoking, while others seem to obtain great personal pleasure from smoking after eating or other activities. A large percentage of the adult population seems unable to work without smoking at intervals during the day. Less anecdotally, there is the implicit assumption by the Joint Committee on Human Rights in its Sixth Report that smoking is an activity, interference with which would engage Article 8: see the Divisional Court's summary, attached as Appendix A, paragraph 19. It seems to me that for many people it forms an important part of their personal lives and possesses a value which reaches a level which qualifies for protection under Article 8 as part of their personal autonomy. For many it may have an importance equivalent to that which hunting had to the claimants in the *Countryside Alliance* case, who might well have succeeded on this aspect of their case, had hunting been an activity which could be conducted in private.

101. That protection is all the more appropriate where the activity in question is taking place in the person's home or in some other institution where he or she resides for a substantial amount of time. That appears to have been the government's own view when it introduced the clause which is now section 3 of the Health Act 2006, empowering the Secretary of State to exempt certain premises, such as homes, hotels, care homes, prisons and other places where a person may be detained, from the prohibition on smoking in enclosed or substantially enclosed areas. As the Secretary of State said at the time, the new power was

> "necessary to exempt from the ban people's own homes and places that are, in effect, someone's home, at least temporarily – in other words, long-term residential care homes, hospitals and *mental health hospitals for adults*, prisons and hotel bedrooms. We are taking the power to make the limited exemptions not only because we believe it is right in principle, but to fulfil our obligations under the Human Rights Act 1998 *on respect for private life*." (Hansard, 14 Feb 2006, col. 1293-4. Emphasis added).

102. I quite accept the point made by the majority that, if Article 8 is engaged by a ban on smoking in the home or the institutional equivalent to the home, it could also be engaged if government were to prohibit the playing of chess or bridge or listening to music, and so on. But I do not regard that as an obstacle to regarding Article 8 as being engaged – indeed, quite the opposite. One would hope that, were the executive to seek to interfere with such activities when conducted in private, it would be required to justify the interference under Article 8(2). But such justification can only be required if Article 8 is engaged in the first place. At this stage in the analysis one is not considering whether Article 8 is breached but merely whether it is engaged.

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

104. Difficult though the judgment necessarily is, I conclude that, for the above reasons, Article 8 is engaged by the terms of Regulation 10(3), which in effect now applies a prohibition on smoking to those in such institutions as Rampton. It was conceded by Mr Swift for the Secretary of State that she was aware that the absence of any exemption for mental health units beyond 1 July 2008 would mean that some patients would face a complete ban on smoking because they would not be allowed to go outside and so would be confined to enclosed areas. That is a factual consequence of the absence of any longer-term exemption, and it is against that impact that the proportionality of the decision has to be judged.

105. I put it like that, as one now has to move on to consider whether that decision by the Secretary of State can be justified under Article 8(2) as being

> "necessary in a democratic society in the interests of "

one of the stated objectives. It is well established that in applying Article 8(2), as with a number of the other qualified articles in the Convention, a court must ask, first, if there is a rational connection between the objective in question and the means being employed to achieve it (see *James v. United Kingdom* [1986] 8 EHRR 123, paragraph 50), and secondly, whether the interference with the right is proportionate to the objective pursued. The first of those questions gives rise to no problem in the present case: the prohibition generally on smoking in enclosed workplaces or public places is rationally connected to the stated aim of protecting people against the risks to health from second-hand smoke.

106. But whether the absence of an exemption in respect of secure mental hospitals is proportionate is a much more difficult question. The Divisional Court in the present proceedings approached that issue in the way suggested by the Privy Council in *de Freitas v. Permanent Secretary of Ministry of Agriculture, Fisheries, Land and Housing* [1999] 1 AC 69, 80, a passage much relied on in later years, where the final requirement was expressed thus:

> "(iii) the means used to impair the right or freedom are no more than is necessary to accomplish the objective."

That test has been endorsed by the House of Lords in *R (Daly) v. Home Secretary* [2001] 2 AC 532, paragraphs 27,29 and 34.

107. The principal objective of the prohibition on smoking in enclosed workplaces and public places is to protect people against other people's smoke – second-hand smoke. But it has not been demonstrated by the Secretary of State that that requires what is in effect a complete ban on patients in secure mental hospitals from smoking, save to the very limited degree that some of the restricted patients may from time to time be allowed outside under careful supervision. After all, the evidence is that, for a time, smoking was allowed in a designated room in such institutions. But in any event, neither the Scottish Executive nor the Welsh Assembly have found it necessary to impose such a total ban on smoking in the interiors of mental health hospitals and units. As the evidence of Mr Andrew Black, filed on behalf of the Secretary of State, reveals, both bodies have adopted the solution of allowing such institutions to have a designated smoking room, and in neither case is there a time limit on that situation. Yet in both countries the same public health objective is being pursued. At one point

in the hearing before us, Mr Swift conceded that that Scottish and Welsh experience shows "that that option is available".

108. I readily acknowledge that, in assessing proportionality in a matter like this, weight has to be attached to the position endorsed by the democratically-elected body. However, nothing put before this court demonstrates that Parliament ever appreciated that in reality the consequence of Regulation 10(3), the time-limit on exemption for mental health units, was likely to be a complete or virtually complete ban on smoking for those detained in secure mental hospitals. There was no debate on the merits of such an outcome, which means that there has been no democratic endorsement of it. Ultimately, the decision is one for the court. In the light of the matters to which I have referred, it seems to me that the prohibition in England on smoking in institutions like Rampton, a prohibition which results from the cessation of the exemption in Regulation 10 plus the security considerations applicable there, is more than is necessary to accomplish the public health objective of protecting people against second-hand smoke. It is therefore disproportionate, and there is a breach of Article 8.

109. In those circumstances I can deal more briefly with the remaining issues. So far as Article 14 is concerned, it follows from what I have already said that I regard the facts of this case as, at the very least, falling "within the ambit" of Article 8 and so meeting the test set out in *Rasmussen v. Denmark* [1985] 7 EHRR 374 at paragraph 29. There is a difference in treatment under the Exemption Regulations between those criminal offenders without serious mental health problems and those with such problems. Those who are detained in prison are exempted from the smoking ban by virtue of regulation 5, in that "rooms" in prisons may escape the ban by being designated, but those offenders who are the subject of orders under sections 37 and 41 of the Mental Health Act 1983 (hospital orders and restriction orders) enjoy no such exemption. Such a difference in treatment is prima facie discrimination.

110. Is the discrimination on one of the grounds prohibited by Article 14? The one relied on by the appellants is "other status". That, according to the Strasbourg jurisprudence, will include discrimination on the basis of a personal characteristic possessed by the person in question:

> "The Court first points out that Article 14 prohibits, within the ambit of the rights and freedoms guaranteed, discriminatory treatment having as its basis or reason a personal characteristic ('status') by which persons or groups of persons are distinguishable from each other.": *Kjeldsen, Madsen and Pedersen v. Denmark* [1976] 1 EHRR 711, at paragraph 56.

It seems indisputable that a mental illness or other mental disability falls within the scope of the term "personal characteristic", as Mr Bowen for the appellants contends. The remaining question, therefore, under this head is whether such discrimination can be justified and is proportionate, proportionality operating in this context just as it does elsewhere in the Convention: see *Belgian Linguistic Case* (No. 2) [1968] 1 EHRR 252, at 284, paragraph 10. Article 14 will be violated if there is no reasonable relationship of proportionality between the means employed and the aim sought to be realised. That is a topic which I have already addressed earlier when dealing with the Article 8 issues, and my conclusion is the same, namely that the failure to exempt

secure mental hospitals from the prohibition on smoking indoors, with its real-life consequences, is not proportionate to the aim which it is sought to realise. That being so, I conclude that there has also been a breach of Article 14 as a result of regulation 10(3).

111. The position of the Trust seems to me to be somewhat different. It has no power now to allow smoking within the enclosed parts of Rampton Hospital because of the terms of regulation 10(3). It could allow those detained at Rampton to smoke outside in the grounds, but I am persuaded by the Trust's evidence that the extent of staff supervision required for dangerous patients to be allowed into the grounds in order to smoke and the high cost thereof makes the Trust's decision not to allow that to happen a reasonable and proportionate one. Moreover, the Trust owes a duty of care to those who are patients in Rampton, who are by definition mentally ill and in consequence may be vulnerable, and that too must be weighed in the scales when deciding whether its decision is proportionate. For those reasons, I would not regard the Trust as being in breach of Article 8 or Article 14 of the Convention.

112. It follows that, for my part, I would allow these appeals in respect of regulation 10 of the Exemption Regulations but dismiss them insofar as they relate to the decision of the Trust.

## Appendix A

a) **<u>Public Documents</u>**

16. The 1998 White Paper "Smoking Kills" estimated that smoking in the United Kingdom caused each year 46,500 deaths from cancer and 40,300 deaths from all circulatory diseases. Those who smoke regularly and who then die of smoking-related diseases lose on average 16 years from their life expectancy when compared with non-smokers.

17. In reports of 1998 and 2004, the Scientific Committee on Tobacco and Health concluded that exposure to second-hand smoking ("SHS") was a cause of a range of serious medical conditions and recommended restrictions on smoking in public places and work-places so as to protect non-smokers from SHS. The overall increased risk of lung cancer for non-smokers exposed to SHS was put at 24%. In December 2005, the House of Commons Health Committee reported that SHS caused at least 12,000 deaths a year in the United Kingdom and, of those deaths, 500 of them were due to the presence of smoke in the workplace.

18. The position of mental health patients was considered by the Health Development Agency Guidance. In 2004, it issued a document entitled "Smoking and patients with mental health problems". That provided: "The smoke-free policy is designed to clarify where smokers can smoke, not whether they smoke" and "smoking should not take place in the buildings, but in a safe and discrete outdoor environment".

19. When the 2006 Act was under consideration, there was extensive consultation about the proposed smoking ban. In its First Report of the Session 2005-2006, the House of Commons Health Committee reported: "Moreover, recent research shows that public support is moving rapidly and decisively in favour of a comprehensive ban on smoking in public places and workplaces" (paragraph 54). However, in its Sixth Report of Session 2005-2006, the Joint Committee on Human Rights of the Houses of Parliament considered the possible impact of the Health Bill on human rights. The Committee considered potential "interference with smokers' article 8 rights" and appear to have contemplated that the article would be engaged. The report stated, at paragraph 1.37:

> "In view of the evidence relied on in support of the proposed prohibition, the fact that it does not extend to a person's home, and that provision is made to exempt places which are peoples' de facto homes, the interference with the private life of smokers is in our view likely to be upheld as being proportionate."

20. To demonstrate the purposes of the statute, Mr Bowen relies in particular on Ministerial statements during the passage of the Bill which became the 2006 Act. In the debate on the third reading, the Secretary of State stated (Hansard 14 February 2006, columns 1293-1294):

> "The new clause provides a general power to make exceptions from the smoking ban. This is necessary to exempt from the ban people's own homes and places that are, in effect, someone's home, at least temporary – in other words, long-term adult residential care homes, hospitals and mental health hospitals for adults, prisons and hotel bedrooms. We are taking the power to make the limited exemptions not only because we believe that it is right in principle, but to fulfil our obligations under the Human Rights Act 1998 on respect for private life".
>
> ". . . We believe that it is right for prisoners, who quite properly have no choice about where they live, to be able to exercise choice in the matter of smoking within appropriate restrictions. My Department and the Home Office are discussing with the prison authorities precisely the nature of the limited exemption that should apply in prisons".
>
> ". . . I do not believe . . . that it would be right to legislate to ban people from smoking in their homes".
>
> (Column 1295): "As I indicated, the issue is how we strike the right balance between protecting people from harm on the one hand and protecting people's freedom of choice on the other".

21. The Government's response to the Health Select Committee recommendations of December 2005 stated, in relation to mental health units:

> "The issue of smoking in psychiatric institutions is complex and is a matter that is currently under consideration. The Government is

considering evidence from a range of sources, including the Health Select Committee, before any final decisions are made".

22. The 2006 Act received Royal Assent on 19 July 2007. On 17 July, the Department of Health issued a further consultation document entitled "Consultation on proposed regulations to be made under powers in the Health Bill".

23. The proposal at that stage of the Department of Health was to exempt "designated rooms" within "mental health units that provide long-term residential accommodation" from the smoke-free requirements in the Health Act. This proposed exemption was to be permanent and was to be of the same type as that proposed for prisons, care homes and hospices.

24. Five hundred and fifty responses to the consultation paper were received. One hundred and fifty responses dealt with the issue of mental health and, of those, 65% suggested that the appropriate course was for either no exemption to be granted for mental health units or for only a time-limited exemption. Only 20% either agreed with the proposed indefinite exemption for mental health units in the consultation paper or proposed a broader exemption.

25. The Disability Rights Commission ("DRC") made the points, first, that their analysis of 8 million primary care records confirmed a very high smoking rate among those with long-term mental health problems and, secondly, that people with serious mental health problems were more likely than other citizens to experience heart disease, hypertension, respiratory disease, diabetes, stroke, breast cancer and bowel cancer.

26. Further, the DRC pointed out, first, that this group suffered from these illnesses for longer periods than other members of the community and, secondly, that they then died of these illnesses faster than other members of the community. The Commission concluded that this material meant "that a very good reason is needed to depart from the principle of a smoke-free NHS".

27. Support for the notion that mental health units should be smoke-free also came from the Royal College of Psychiatrists which noted that these patients "have difficulty in stopping smoking in an environment in which nearly 70% of their peers smoke and where smoking can become an occupation per se with non-smokers known to begin smoking in psychiatric units". The Royal College concluded, first, that the benefits of having smoke-free hospitals for long-stay patients would out-weigh the short-term difficulties and, secondly, that an exemption of long-stay psychiatric patients from the Health Act would discriminate against psychiatric patients by excluding them from the important benefits of mainstream health improvements and would further extend the health inequalities that psychiatric patients and those who work with them were already experiencing.

28. The Royal College of Physicians expressed the view in October 2006 that there should be no exceptions for mental health units, irrespective of the likely duration of residence. They stated that "the provision of exemptions for longer stay institutions discriminates against people with serious mental health problems and those who work with them, by denying them a safe environment . . . In special circumstances, such as secure units in which provision of secure or otherwise suitable safe smoking areas

presents especial practical difficulty, it would be reasonable to allow a longer period of implementation . . . but the object should remain to achieve smoke-free status in all mental health facilities within a reasonable period (of perhaps 2-3 years) defined within the regulations. The provision of comprehensive smoking cessation support services to underpin the smoke-free policy should clearly be obligatory."

29. Many respondents quoted from the King's Fund study published in 2006 entitled "Clearing the Air: Debating smoke-free policies in psychiatric units", which reported findings that:

> "Epidemiological studies suggest chronic smoking is associated with agoraphobia, generalised anxiety disorder and panic disorder... smokers have higher rates of and experience more severe depression are more likely to think about suicide and have higher suicide rates"

30. We acknowledge that there was a substantial body of opinion, which the Secretary of State would be expected to take into account when placing regulations before Parliament, supporting an indefinite or a time-limited exemption. These included the Mental Health Act Commission ("the MHAC"), the British Medical Association, Cancer Research UK and many NHS organisations.

31. The MHAC expressed the view that patients who are deprived of their liberty under the Mental Health Act should not, as a consequence, be deprived of the choice to smoke. Other points made were that not being able to smoke can add to the distress of patients at a difficult time and might be counter-productive to the patient's care and welfare. While it will not directly affect patients at Rampton, it is also submitted that a blanket ban on smoking could deter potential patients from seeking help from inpatient services, possibly resulting in more admissions under the Mental Health Act.

32. The 2007 Regulations followed. Describing the intended impact of the regulations, the National Clinical Director for Mental Health wrote, on 1 February 2007:

> "From 1 July 2008, smoking will be against the law in any enclosed or substantially enclosed part of any mental health establishment."

b) **Evidence**

33. In a statement prepared for the present case dated 18 January 2008, Mr AW Black, who was between January 2006 and September 2007 leader of the Smoke-free Legislation Team within the Department of Health, gave the main reasons for the decision to provide, for mental health units, only a temporary exemption from the smoke-free legislation. He stated (we summarise) that conclusive scientific evidence showed that second-hand smoke poses significant risks to the health and wellbeing of those exposed to it. Secondly, during the passage of the Bill, a large cross-party majority supported broad smoke-free provisions. Thirdly, the primary purpose of mental health units is to provide healthcare and to promote the physical and mental health of the patients. The evidence received suggested that chronic smoking is associated with, and may even intensify, some mental disorders. Fourthly, evidence and research demonstrated the feasibility of making mental health units smoke-free in the short-term, whereas the Department had previously only considered that to be

possible in the longer term. Evidence and previous experience had shown that mental health units can feasibly become smoke-free and that prohibitions on smoking indoors are better received and complied with by patients than partial smoking bans.

34. Mr Black referred in detail to the assistance available to patients in mental health units to stop smoking. He added:

> "Finally, a 12-month 'sunset clause' was provided for residential mental health units, rather than no exemption at all, in order to allow sufficient time for these premises to prepare for the implementation of the smoke-free provisions. Given that, at the consultation stage, the proposal had been to provide an indefinite exemption for long-term residential mental health units, they had had less time to prepare for the smoke-free provisions coming into force than other bodies who had no expectation that they might be made exempt."

35. On the issues both of engagement of article 8 and of article 8(2), the claimants rely on the evidence of Professor Jane Powell, Professor of Psychology at Goldsmiths, who has dual specialisms in addictions and neurophysiological rehabilitation. Professor Powell stated (letter of 14 January 2008) that she had been asked "to provide the court with relevant information to weigh alongside and against other data in coming to its judgment . . . It is for the court to decide what weight, if any, to assign to these various issues". Among the points made by Professor Powell are:

> (a) For people with neurological or psychiatric conditions, nicotine may enhance cognitive functioning relative to their normal level.
>
> (b) There is considerable evidence that schizophrenia is characterised by specific cognitive deficits which are attenuated, at least acutely, by nicotine.
>
> (c) There is evidence that smoking has subjectively greater salience and perceived benefits for people with a mental disorder than for those who do not. Patients with mental disorders find that the short-term psychological effects of smoking are perceived to be of value.
>
> (d) The probabilities of reporting smoking for its calming and cheerful effects are related to the level of anxious and depressed symptoms experienced by schizophrenic patients, though there is no evidence that cessation worsens the overall behavioural disturbances of schizophrenia.
>
> (e) It is crucially important to provide additional support if the imposition of a ban is to achieve any longer-term change in patients' motivation to smoke.

36. In summary, Professor Powell states that the evidence she has summarised "strongly suggests both that smoking does produce acute benefits to many patients with mental disorder in terms of its enhancement of certain cognitive processes, and also that subjectively they perceive smoking to be more helpful in coping with stress and in

enhancing mood than do smokers who do not have mental disorders". Lay evidence is also submitted to demonstrate the benefits of smoking to those with depression and other forms of mental illness.

37. The Trust have obtained a medical report in reply from Professor Griffiths Edwards CBE, Emeritus Consultant Psychiatrist, Bethlem and Maudsley Hospitals, Emeritus Professor of Addictive Behaviour, University of London. In summary, he considers that to recommend smoking as a treatment for schizophrenia or for the prevention of depression would be unethical. He says that Professor Powell's findings on the possible benefits of smoking, which may be clinically rather slight, failed to take into consideration the undoubtedly significant potential harms. Effective replacement therapy is available. There is no evidence that nicotine withdrawal is likely to lead to behavioural disturbance in the mentally ill.

38. In relation to the exemptions in the policy, Dr JM Harris Executive Director of the Forensic Division stated:

> "The consideration for the exemptions will be within the patient's own Clinical Team and would have to demonstrate both some benefit to the patient in being able to be exempted from the policy, i.e. it might help to relieve the symptoms of the acute exacerbation of their mental illness, and it was technically feasible. For Rampton Hospital this can sometimes cause a significant difficulty because of the very nature of having a hospital on three floors and because of the variability of some patients."

39. It is primarily relevant to a consideration of article 8(2) but we mention at this stage the evidence that, since a smoke-free policy was introduced in Rampton with effect from 31 March 2007, none of the disturbing consequences feared by the claimants have occurred. There has been no increase in the prescription of sedative drugs. Dr Larkin, a Consultant Psychiatrist and Associate Medical Director at Rampton, confirms that there have been health benefits such as fewer problems and medication related to asthma and respiratory matters as well as a reduction in manipulative behaviour associated with cigarettes, such as bribery, exploitation and bullying of vulnerable patients. This is consistent with the evidence of both Professor Edwards and Professor Powell that nicotine withdrawal has not led to behavioural disturbance. They also recognised difficulties inherent in any partial ban.