IN THE SUPREME COURT OF VICTORIA
AT MELBOURNE
COMMON LAW DIVISION
JUDICIAL REVIEW AND APPEALS LIST

Not Restricted

S CI 2015 02936

ROBERT PETER DE BRUYN
(by his Litigation Guardian, Gary Michael de Bruyn) Plaintiff

v

VICTORIAN INSTITUTE OF FORENSIC MENTAL HEALTH Defendant

JUDGE:	RIORDAN J
WHERE HELD:	MELBOURNE
DATE OF HEARING:	1,2,3 DECEMBER 2015
DATE OF JUDGMENT:	22 MARCH 2016
CASE MAY BE CITED AS:	DE BRUYN v VICTORIAN INSTITUTE OF FORENSIC MENTAL HEALTH
MEDIUM NEUTRAL CITATION:	[2016] VSC 111

MENTAL HEALTH ACT 2014 (VIC) – Whether the imposition of a smoke free policy was within the statutory power of a hospital.

TOBACCO ACT 1987 (VIC) – Whether there is an implied statutory right to smoke.

CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES ACT 2006 (VIC) – Whether a smoking ban engaged an involuntary patient's human rights to be treated with dignity under s 22(1), appropriately for a person who has not been convicted under s 22(3), and/or not to be subjected to compulsory medical treatment under s 10(c) – Whether a person found not guilty by reason of insanity is 'detained without charge' within the meaning of s 22(3) – Whether a hospital, in adopting a smoke free policy, had given proper consideration to relevant human rights in accordance with s 38(1).

APPEARANCES:	Counsel	Solicitors
For the Plaintiff	Mr R Hay QC Mr M Albert	Burke & Associates
For the Defendant	Mr C Horan SC Ms J Davidson	Corporate Counsel, Victorian Institute of Forensic Mental Health
For the Attorney General	Ms M Richards SC Ms J Watson	Victorian Government Solicitor

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HIS HONOUR:

Introduction

1 The plaintiff, Mr Robert de Bruyn, is an involuntary patient at Thomas Embling Hospital ('the Hospital'), a clinical services facility of the defendant, the Victorian Institute of Forensic Medicine, also known as Forensicare. The plaintiff, by his litigation guardian, seeks declaratory and injunctive relief against the defendant to prevent the implementation of a smoke free policy at the Hospital.

2 The smoke free policy, as adopted by the defendant, has applied to all of the defendant's sites from 1 July 2015 ('the Smoke Free Policy'). In summary, it provides as follows:

(a) Smoking is not permitted anywhere on the defendant's premises or grounds including outdoor areas.

(b) Cigarettes, tobacco, electronic cigarettes and smoking paraphernalia are considered contraband as defined in the Contraband Policy approved on 20 October 2014 and will be liable to be 'reported and stored'. People in possession of such items will be prevented from entering the grounds of the defendant's premises.

3 By an originating motion between parties filed on 9 June 2015 and amended on 6 August 2015 pursuant to the order of Ierodiaconou AsJ made on 3 August 2015, the plaintiff seeks orders pursuant to O 56 of the *Supreme Court (General Civil Procedure) Rules 2015* as follows:

> 1. An order prohibiting the implementation of the Smoke Free Policy;
>
> 2. A declaration that the Smoke Free Policy is beyond the power of the Defendant;
>
> 3. A finding that the Defendant, as a public authority for the purposes of section 4(1)(b) of the *Charter of Human Rights and Responsibilities 2006* (Vic), will breach the human rights of the Plaintiff to not be deprived of his property other than in accordance with law under s 20 and/or to be treated with humanity and with respect for the inherent dignity of the human person under s 22(1), and acted unlawfully under s 38(1) of the

Charter in seeking to impose the Smoke Free Policy at the Thomas Embling Hospital;

4. An order that the Defendant pay the Plaintiff's costs of this proceeding;

5. Such further or other order as the Court deems fit.

4 The grounds relied upon by the plaintiff are as follows:

(a) The Smoke Free Policy is:

(i) beyond the power of the defendant because it falls outside the powers given to it by the *Mental Health Act 2014*; and/or

(ii) unlawful because it is inconsistent with the *Tobacco Act 1987* ('the *Tobacco Act*').

(b) The defendant breached its obligations under s 38 of the *Charter of Human Rights and Responsibilities Act 2006* ('the Charter') not to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right when it decided to approve and/or adopt the Smoke Free Policy in that it will, if implemented, breach the human rights of the plaintiff to:

(i) not be deprived of his property other than in accordance with law under s 20; and/or

(ii) be treated with humanity and with respect for the inherent dignity of the human person under s 22(1); and/or

(iii) be treated in a way that is appropriate for a person who has not been convicted under s 22(3).

Further, at the trial of the proceeding, the plaintiff applied for leave to further amend the originating motion to allege a breach of the human right not to be subjected to medical treatment without his full, free and informed consent under s 10(c) of the Charter.

5 On 29 June 2015, the defendant gave an undertaking to the Court not to implement the Smoke Free Policy with respect to the Jardine Unit, a unit of the Hospital where the plaintiff is currently an inpatient, until determination of this application.

6 For the reasons set out below, I have decided the questions for determination as follows:

(a) The approval and adoption of the Smoke Free Policy is within the powers of the defendant under the *Mental Health Act 2014*.

(b) The Smoke Free Policy is not inconsistent with the provisions of the *Tobacco Act*.

(c) In approving and adopting the Smoke Free Policy, the defendant has not failed to give proper consideration to the plaintiff's human right under s 20 of the Charter not to be deprived of his property other than in accordance with law because the defendant has not to this time made a decision not to return smoking paraphernalia to the plaintiff.

(d) In approving and adopting the Smoke Free Policy, the defendant has not failed to give proper consideration to the plaintiff's human right under s 22(1) of the Charter to be treated with humanity and with respect for the inherent dignity of the human person because:

(i) the Smoke Free Policy does not engage the human right under s 22(1); and in any event

(ii) the defendant did give proper consideration to the human right under s 22(1).

(e) In approving and adopting the Smoke Free Policy, the defendant has not failed to give proper consideration to the plaintiff's human right under s 22(3) of the Charter to be treated in a way that is appropriate for a person who has not been convicted because:

(i) the Smoke Free Policy does not engage the human right under s 22(3); and in any event

(ii) the defendant did give proper consideration to the human right under s 22(3).

(f) The plaintiff should have leave to further amend the originating motion to allege that the defendant failed to give proper consideration to the plaintiff's human right not to be subjected to medical treatment without his full, free and informed consent under s 10(c) of the Charter.

(g) In approving and adopting the Smoke Free Policy, the defendant has not failed to give proper consideration to the plaintiff's human right under s 10(c) of the Charter not to be subjected to medical treatment without his full, free and informed consent because the Smoke Free Policy does not engage the human right under s 10(c).

Background

7 I propose to set out the background facts with considerable detail because they will be cross-referenced to my reasons for finding that the defendant gave proper consideration to the relevant human rights.

8 The background facts with respect to the plaintiff are as follows.

(a) The plaintiff is 49 years of age.

(b) In 1982, the plaintiff was diagnosed as suffering from schizophrenia.

(c) On 8 August 1989, the plaintiff was found not guilty of the charge of murdering his mother by reason of insanity and ordered to be detained in custody pursuant to s 420 of the *Crimes Act 1958* until the Governor's pleasure be known. He has been treated for paranoid schizophrenia since that time.

(d) Since April 2000, the plaintiff has been an involuntary resident of the Hospital.

(e) In 2014, as a result of an improvement in his mental state, the plaintiff was moved to the Jardine Unit of the Hospital.

(f) Since about September 2014, the plaintiff has been granted 'day leave' in which he is permitted to leave the Hospital grounds unescorted between the hours of 7 am and 9 pm, subject to notification to Hospital staff on the day before and psychiatric assessment one hour before any proposed departure from the Hospital grounds.

9 The evidence about the Hospital is as follows:

> [It] is a 116-bed secure mental health facility located in Yarra Bend Road, Fairfield, Victoria. The Hospital commenced operation in 2000, and is a 'designated mental health service' under the *Mental Health Act* which is funded by the Department of Health and Human Services.
>
> The Hospital is situated on Crown land which was reserved as a site for health and social welfare purposes under s 13 of the *Land Revocations (And Other Matters) Act 1995* (Vic). The Secretary to the Department of Health has been appointed as the committee of management of the land for the purposes of the *Crown Lands (Reserves) Act 1978*. …
>
> Patients in the Hospital hold one of three legal statuses under the *Mental Health Act*:
>
> a. 'compulsory patients' (or civil patients);
>
> b. 'forensic patients' – people found unfit to plead or not guilty by reason of mental impairment and made subject to custodial supervision under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*; and
>
> c. 'security patients' – remanded and sentenced prisoners transferred for involuntary treatment under section 276 of the Act.
>
> Thomas Embling Hospital is the only designated mental health service in Victoria which accommodates forensic patients and security patients.
>
> Within the high secure perimeter of the Hospital there are six (6) residential units:
>
> a. Argyle – 15 bed male acute assessment unit;
>
> b. Atherton – 15 bed male acute assessment unit;
>
> c. Barossa – 10 bed women's acute assessment unit;
>
> d. Bass – 20 bed male sub-acute unit;

e. Canning – 20 bed male extended care unit; and

f. Daintree – 20 bed mixed gender rehabilitation unit.

Outside of the high secure perimeter is Jardine, a 16-bed mixed gender community reintegration unit which has its own low secure perimeter.

…

Within the secure perimeter of the Hospital, there is open space and buildings separate to the residential units which house education facilities, a kiosk, a gym and a pool. The freedom of patients to leave the unit in which they reside varies from unit to unit, and depends on approval being given for campus access. The grant of approval depends on an assessment of the risk that the person presents to themselves or to others on the campus.

Smoking restrictions at the Hospital

10 In March 2006, the *Tobacco Act* was amended to ban smoking in workplaces that were substantially enclosed. The defendant was granted an exemption under the *Tobacco Act* enabling it to provide designated indoor smoking areas in the Argyle, Atherton, Bass, Barossa and Canning acute units of the Hospital, where patients did not have general access to the Hospital grounds. Although smoking was otherwise prohibited within the Hospital building from 1 March 2006, smoking was permitted in the outdoor area of the Jardine Unit.

11 The process of the implementation of a smoke free environment at the Hospital began with a smoke free pilot in the Jardine Unit from February to July 2011.

12 In May 2011, Dr Maurice Magner, the Clinical Director of the defendant, met with the Consumer Advisory Group, a representative committee consisting of a patient representative from each unit or program at the Hospital, including the plaintiff, and informed members of the group that the Hospital should go smoke free 'a couple of years' into the future. Meetings of the Consumer Advisory Group were chaired by a consumer consultant (being a person employed by the Hospital who has a direct or 'lived' experience of mental illness).

13 Minutes of the meeting of the Consumer Advisory Group on 6 June 2011 indicate that members were not happy with the smoke free proposal and asked that Dr Magner

and a representative of a consumer advocacy organisation, the Victorian Mental Illness Advisory Council, attend its next meeting.

14 On 4 July 2011, Dr Magner and Ms Isabell Collins, a representative of the Victorian Mental Illness Advisory Council, attended the Consumer Advisory Group meeting for the purpose of leading a discussion about the smoke free proposal. Dr Magner presented arguments in support of the proposal and Ms Collins presented arguments against it. The issues raised at the meeting included the following:

(a) Smoking is a human right and is not illegal.

(b) Smoking is a serious addiction.

(c) It would be cruel to stop a sick patient from smoking.

(d) The Hospital is home for many patients who spend many years there.

(e) The importance of having a long term quitting program.

(f) Hospitals should treat patients holistically.

(g) Both staff and patients had continued to smoke during the partial ban in the Jardine Unit.

The Consumer Advisory Group resolved to keep the issue of the smoke free proposal on its agenda as a standing item.

15 On 7 May 2012, the Executive Director of Inpatient Services at the Hospital attended a meeting of the Consumer Advisory Group and talked about the defendant's intention to make the Hospital a smoke free environment at some time in the future.

16 On 29 May 2012, the minutes of the meeting of the defendant's Council[1] record the following report of Dr Magner with respect to 'Forensicare: A No Smoking Zone':

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[1] Dr Magner gave evidence that 'the Council' became 'the Board' however for consistency it will be referred to throughout this judgment as 'the Council'.

> Senior managers and clinicians have been talking about the need to move towards a no smoking policy at Forensicare. There can be little dispute that this would be a healthy development for both patients and staff.
>
> I propose that Council considers adopting a resolution to support a plan to move to no smoking at Forensicare. The details of when and how this will be achieved will be presented to Council in due course.

17 By email dated 31 May 2012 to staff of the defendant, Dr Magner said as follows:

> Today is World No Tobacco Day.
>
> …
>
> At Forensicare we are celebrating World No Tobacco Day today, May 31, 2012 by announcing the first stage of a plan to become a smoke free service. From July 1 this year we will require all staff and contractors to smoke in designated areas within Thomas Embling Hospital and the corporate administration area, while the Community Forensic Mental Health Service already has designed areas. Our prison services are governed by the decisions of Corrections Victoria and while Justice Health is reviewing smoking in prisons no changes are planned at present.

The email attached the defendant's new policy on 'Smoking Restrictions for Employees, Patients and Visitors'.

18 At the meeting of the Consumer Advisory Group on 4 June 2012, the consumer consultants said that they would attend Hospital unit community meetings to find out patient views about the smoke free proposal.

19 At the defendant's Council meeting in June 2012, Dr Magner provided a 'briefing attachment' to his report about a total smoking ban at the premises of the defendant. The attachment stated as follows:

> Forensicare – a no smoking zone
>
> Cigarette smoking is a serious addiction. There is little debate any more about the health risks of both active and passive smoking. Policies are being implemented around the globe which seek to reduce and restrict smoking.
>
> Forensicare seeks to improve the wellbeing of its patients and clients and at the same time promote the wellbeing of its staff.
>
> Forensicare has a duty to provide a healthy and safe environment for everyone.
>
> The experiences of Melbourne Health institutions in attempting to implement various smoke free policies has been mixed. Largely failures have been related to the very short term nature of admissions and the openness of their services.

> Prisons in New Zealand have successfully implemented smoke free policies. Forensic services in the UK have published their experience with successful smoke free policies. The restrictive forensic environments provide an excellent opportunity to support people over their addiction and on to a smoke free life. There are numerous smoking cessation supports available to meet a variety of needs.
>
> What Forensicare requires to successfully achieve a goal of being a smoke free zone is the commitment from the Council, the Executive and the clinical staff to working towards that goal.
>
> Some steps are already underway. Recently a new policy has been implemented which further restricts the areas in which staff and patients may smoke. Patient consumers and patient advisory group have been informed that we do plan to move towards a smoke free policy.
>
> In order to achieve smoke free status there is considerable preparation required. This includes informing people, accessing smoking cessation supports, making clinical staff aware of the implications (e.g. changes to medication dose), engaging families and carers, dealing with the legal challenges. Conservatively this would take one year to work through.
>
> I believe it is important for the Council to make a clear statement of intent that Forensicare will be smoke free from 1st Jan 2014. This would provide the necessary incentive for the Executive to form a task group to get on with the processes and inform the Council from time to time of progress.

20 On 23 August 2012, Dr Magner made a presentation to the defendant's Council seeking in principle support for making the Hospital a smoke free environment. The presentation included the following:

> There is a substantial body of literature on the effects of smoking for people with a mental illness. There is also a growing body of literature on mental health services and prisons going 'smoke free'. Some of this literature is provided to Council electronically with this briefing.
>
> **Legal Issues**
> In Victoria the *Tobacco Act 1987* provides for the creation of smoke free environments in recognition of the harmful effects of smoking, particularly passive smoking. The *Tobacco Act* prohibits smoking in enclosed workplaces, including mental health services, unless an exemption is granted by the Secretary. Forensicare currently has an exemption from this general ban which provides for designated smoking courtyards in the acute units where patients do not have general access to the hospital grounds. The *Tobacco Act* does not prohibit smoking in hospital grounds.
>
> A number of hospitals in Victoria and other states of Australia have introduced totally smoke free environments. Forensicare is now intending to introduce a totally smoke free environment at Thomas Embling Hospital. This is in line with Forensicare's legal obligation under the *Occupational Health and Safety Act 2004*, to 'so far as is reasonably practicable, provide and maintain for

employees of the employer a working environment that is safe and without risks to health' (see section 21).

Whilst the OHS Act does not provide a clear authority for the protection of patients from the harmful effects of passive smoking, to do so is sensible from a legal and risk management point of view. However, it is not clear whether banning smoking in the hospital grounds is necessary in order to provide the required protection to non-smoking patients and staff.

In addition, there may be legal arguments against prohibiting access to smoking for patients who choose to smoke. Another health service in Victoria was recently subject to a claim under the *Equal Opportunity Act* from a patient held under an involuntary treatment order who said that the smoke free environment policy operated in a discriminatory manner for mental health patients who were unable to leave locked units to smoke in designated smoking areas outside the hospital grounds. This claim was settled in mediation so it is unclear whether it is likely to have succeeded.

A further point to note is that a significant proportion of our patients come from prison, where smoking is generally allowed.

Moving Forward
There is much work to be done in implementing any ban on smoking within the Hospital. Consultation with consumers and staff and various advocacy groups will be required. There may also be a need for further legal advice on the issue. At this stage management is seeking endorsement from Council of the principle that the Hospital should be a smoke free environment by January 2014. Further updates on the initiative will be provided as it progresses.

Recommendation
That Council provide 'in principle' support that the Thomas Embling Hospital be a smoke-free environment by 1 January 2014.

The literature which was provided with the presentation included the following:

(a) An article entitled 'How to Implement a Smoke-free Policy' by Irene Cormac and Lisa McNally in 'Advances in Psychiatric Treatment' (2008).

(b) An article entitled 'Impact of a Total Smoking Ban in a High Secure Hospital' by Irene Cormac, Sandra Creasey, Ann McNeil, Michael Ferriter, Bernard Huckstep, and Karen D'Silva from 'The Psychiatrist' (2010).

(c) An article entitled 'Implementation of Smoke-free Policies in Mental Health In-patient Settings in England' by Elena Ratschen, John Britton and Ann McNeill in The British Journal of Psychiatry (2009).

(d) An article entitled 'Nicotine Addiction and Smoking Cessation Treatments' by Jason Luty in 'Advances in Psychiatric Treatment' (2002).

(e) An article entitled 'Review of Smoking Cessation Treatments for People with Mental Illness' by Jonathan Campion, Ken Checinski and Jo Nurse in 'Advances in Psychiatric Treatment' (2008).

(f) An article entitled 'The Experience of a Smoke-free Policy in a Medium Secure Hospital' by Abhijeeth Shetti, Rajesh Alex, and Darran Bloye in 'The Psychiatrist' (2010).

(g) An article entitled 'Prisoners and Cigarettes' or "Imprisoned in Cigarettes"? What helps prisoners quit smoking?' by Elias Makris, Konstantinos Gourgoulianis and Chrysi Hatzoglou in 'BMC Public Health' (2012).

(h) An article entitled 'Smoking Bans and Clozapine Levels' by Mohammed Ashir and Louise Petterson in 'Advances in Psychiatric Treatment' (2008).

(i) An article entitled 'Smoking by People with Mental Illness and Benefits of Smoke-free Mental Health Services' by Jonathan Campion, Ken Checinski, Jo Nurse and Ann McNeil in 'Advances in Psychiatric Treatment' (2008).

(j) An article entitled 'Smoking Restrictions and Treatment for Smoking: Policies and Procedures in Psychiatric Inpatient Units in Australia' by Paula Wye, Jennifer Bowman, John Wiggers, Amanda Baker, Jenny Knight, Vaughan Carr, Margarett Terry and Richard Clancy in 'Psychiatric Services' (January 2009).

(k) A report of the National Centre for Social Research entitled 'Cigarette Smoking and Mental Health in England – data from Adult Psychiatric Morbidity Survey 2007' by Sally McManus, Howard Meltzer and Jonathan Campion (December 2010).

(l) A document entitled 'Smoking Mad – Enforced Smoking Bans for Involuntary Patients are a Human Rights Abuse' published at www.smokingmad.blogspot.com.

(m) An article entitled 'Staff Attitudes to Smoking and the Smoking Ban' by Kudlur Thyarappa Praveen, Swamy Nirvana Chandrappa Kudlur, Rudresh Paramishiyaiah Hanabe and Adeyemi Tiwalade Egbewunmi in 'The Psychiatrist' (2009).

(n) An article entitled 'Survey of Staff Attitudes to Smoking in a Large Psychiatric Hospital' by Jean Stubbs, Camilla Haw and Liz Garner in 'The Psychiatrist' (2004).

(o) An article entitled 'The Smoking Culture in Psychiatry: Time for Change' by Elena Ratschen, John Britton and Ann McNeill in 'The British Journal of Psychiatry' (2011).

21 On 29 August 2012, a Hospital planning group held its first meeting and set 1 July 2014 as the provisional date for going smoke free.

22 The minutes of the Consumer Advisory Group meeting held on 5 November 2012 record the following action arising out of the issue 'The Introduction of Potential Smoking Bans':

> Approximately July 2014 at this stage; however, no definite date set. [REDACTED] talked to CAG members about forming a working party: 'Smoker's Choice' to combat the introduction of smoking bans across the hospital — which may involve petitions, submissions and letters to management. CAG members will notify fellow patients at community meetings re the formation of 'Smoker's Choice' and see whether there are any interested parties who would like to join the working party. [REDACTED] will photocopy [REDACTED] letter & petition and distribute them to CAG members. Both [REDACTED] and [REDACTED] will get involved with 'smokers choice'.

23 The minutes of the Consumer Advisory Group meeting held on 3 December 2012 record the following:

> Nic McAtamney and Wendy Ridley have formed a working party: Smoker's Choice to battle against the proposed introduction of smoking bans at [the Hospital]. Nic joined the CAG meeting and collected signed petitions from CAG members and will collect the unsigned petitions at a later date. Robert and [patient name] have joined the working party and will meet with Nic and Wendy in January 2013.

24 The minutes of the Consumer Advisory Group meeting held on 4 February 2013 record under the agenda item 'Smoker's Choice Group':

> [REDACTED] (co-founder of 'Smoker's Choice Group') has taken up a night shift position. He has received all the petitions and the group will re-convene once [REDACTED] returns to day shift. [REDACTED] and [REDACTED] have joined the group.

25 In April 2013, the Breathe Easy Smoke Free Steering Committee was convened. Membership of the committee initially comprised the Executive Director of Human Resources, the Executive Director of Inpatient and Prison Operations, the Chief Occupational Therapist and Dr Magner. The initial meeting considered that, to recognise staff and patient needs, a broader membership of the committee would include consumer, medical, executive, human resources, occupational therapist, social worker, psychologist, unit manager and nurse representation.

26 At its meeting on 6 May 2013, the Consumer Advisory Group unanimously decided to oppose the smoke free proposal.

27 At the meeting of the Breathe Easy Smoke Free Steering Committee on 8 May 2013, the consumer consultant representative presented a paper which raised a number of issues including the following:

(a) As a significant proportion of patients at the Hospital come from prison, where smoking is generally allowed, it could be argued that prisoners who are transferred to the Hospital due to mental illness will be subjected to discrimination because they will lose the benefit of the choice to smoke due to having mental illness.

(b) There may be legal arguments against prohibiting access to smoking in light of the experience of another health service in Victoria. The service was subject to

a claim under the *Equal Opportunity Act 2010* from a patient held under an involuntary treatment order who claimed the smoke free environment policy operated in a discriminatory manner for mental health patients who are unable to leave locked units to smoke in designated smoking areas around the hospital grounds. The claim was settled at mediation so it was unclear whether it would have succeeded.

(c) Reference was also made to sub-ss 68(a) and 68(f) of the 'Mental Health Act' 'MHA 2007', being what can only be a reference to the New South Wales *Mental Health Act 2007*. The relevant sections provide 'principles for care and treatment' that as far as practicable:

(i) 'People with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given' (s 68(a)); and

(ii) 'Any restriction on the liberty of patients and other people with a mental illness or mental disorder any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances' (s 68(f)).

(d) Staff concerns were outlined.

(e) A series of questions regarding the purpose and composition of the Breathe Easy Smoke Free Steering Committee were also posed, as well as an enquiry as to whether the Charter had been considered.

The presentation attached two articles being:

(i) 'Smoking, Stigma and Human Rights in Mental Health: Going up in Smoke?' by Joanne Warner online in 'Cambridge Journals' (2009).

(ii) 'Evaluation of a Smoke-Free Forensic Hospital: Patients' perspectives on Issues and Benefits' by Angela Herir, Devon Indig, Sharni Prosser and Vicki Archer in 'Drug and Alcohol Review' (2012).

At about this time, an intranet based website ('the Sharepoint Breathe Easy site') was established to make resources available to staff and collate project information. Surveys were developed to gain information from staff and patients about their attitudes to smoking and to a facility-wide ban before implementing any policy changes.

28 On 31 May 2013, World No Tobacco Day, the Breathe Easy Smoke Free Project was formally launched. Staff were advised by email of the following:

(a) The defendant was starting a process of consultation with consumers, carers and staff about becoming a clean air hospital.

(b) The target was to have the Hospital smoke free by 1 July 2014.

(c) Staff were requested to complete a survey.

(d) It was noted that high security hospital services in New South Wales, Tasmania and South Australia have all been smoke free environments for several years.

29 The minutes of the Breathe Easy Smoke Free Steering Committee meeting held on 17 July 2013 record the feedback from the staff survey. It was noted that 60 of the 111 completed responses supported a no smoking policy. It was resolved to invite a QUIT staff member to join the committee to provide expert guidance and possibly staff training.

30 At the meeting of the Breathe Easy Smoke Free Steering Committee held on 31 July 2013, the QUIT staff member recommended that nicotine replacement be given for long enough to fully cover the withdrawal phase, which might necessitate several months of treatment.

31 At the meeting of the Breathe Easy Smoke Free Steering Committee held on 25 September 2013, the results from the patient survey were presented. Patients had been interviewed on a one-on-one basis from June 2013. Seventy-six patient responses had been received from a possible number of approximately 100.

32 The staff and patient survey results were published on the defendant's intranet in October 2013. The results included:

(a) 13% of staff and 68% of patients were smokers;

(b) 60% of staff and 43% of patients supported at least a partial smoke free environment; and

(c) 48% of patients recognised that exposure to smoke was harmful.

33 In October 2013, the defendant joined the Victorian Network of Smoke Free Healthcare Services.

34 In November 2013, Dr Magner recommended to the defendant's Council that the proposed date for the Hospital to become smoke free be moved from 1 July 2014 to 1 July 2015 as a result of the recent announcement from Corrections Victoria of its intention to ban smoking in prisons from July 2015 and the difficulties that could arise for prisoner patients if the defendant and Corrections Victoria implemented policies on different dates.

35 In December 2013, the terms of reference for the Breathe Easy Smoke Free Steering Committee were finalised and identified the committee's responsibilities as follows:

- To develop a 'Smoke Free Environment' policy for Council
- To create an implementation plan that includes stakeholder input
- To develop and recommend solutions to perceived barriers to creating a smoke free environment
- To identify patient supports that should be put in place
- To create a communication plan
- To develop a budget for the implementation of a smoke free environment
- To ensure the sustainability of the initiative

36 By letter dated 12 December 2013 to the families and carers of patients in the Hospital, Mr Tom Dalton, the Chief Executive Officer of the defendant, communicated the decision to make the Hospital a smoke free environment by 1 July 2015.

37 At the meeting of the Breathe Easy Smoke Free Steering Committee held on 7 May 2014, it was agreed that patients as well as staff should be able to undertake two hours of training to become QUIT educated and that the QUIT telephone support line would be available for patients of all units.

38 On 29 May 2014, World No Tobacco Day, the defendant held two smoke free forums. The first forum was for staff of the defendant, contractors and the families and carers of patients at the Hospital. The second forum was for staff and patients at the Hospital. The speakers at each forum included the Chief Executive Officer, a mental health smoking cessation academic and two patients from the Hospital, who would be directly impacted by the Smoke Free Policy and wished to speak in opposition to it.

39 By email dated 2 June 2014, the draft Smoke Free Policy and the draft Smoking Cessation for Staff and Patients Policy were distributed to staff and patients for comment as the result of expert advice. All patients who smoked would be offered 26 weeks of nicotine replacement therapy because mental health patients often required longer-term replacement therapy.

40 On 20 June 2014, the defendant's Chief Occupational Therapist and the QUIT representative met with the plaintiff's brother to discuss his concerns.

41 By a report dated 24 June 2014 to the defendant's Council, the Breathe Easy Smoke Free Steering Committee reported on progress of the smoke free proposal. It noted that the defendant's Executive had endorsed 21 staff and 4 patients as persons who would be trained as smoking cessation specialists, whose major role was to support patients who chose to quit before the 1 July 2015 ban was introduced.

42 At the July 2014 meeting of the Breathe Easy Smoke Free Steering Committee, there were discussions on issues related to the Charter. Dr Magner was aware that one of

the defendant's senior consultant psychiatrists, Dr Danny Sullivan, was writing an article for the 'Journal of Law and Medicine' on the issue of the human rights implications of smoking bans in psychiatric facilities. As a result, on 19 August 2014 Dr Magner sent an email to Dr Sullivan, the substance of which was as follows:

> The Breathe Easy Smoke Free committee has asked if Forensicare could make a statement indicating that we have considered the rights implications of going smoke free.
>
> Corrections have done their own assessment and in particular considered s8 – the right to equality, s10(3) the right to protection from cruel treatment, s22 the right to humane treatment when deprived of liberty and s13 the right to privacy.
>
> Given that they are proceeding with plans to go smoke free in July 2015 I think their view is likely to be that there is no incompatibility with the HRC.
>
> I wondered if you would like to give some comments on this to assist us in preparing some form of statement that needs to accompany the Smoke Free Policy.

43 By email dated 26 August 2014, Dr Sullivan replied as follows:

> My paper will be published in September but is unavailable yet!
>
> The rights of staff and those detained do not appear to enliven any positive duty of public agencies to support access to tobacco, even for detained persons. For instance, considering the Victorian *Charter of Human Rights and Responsibilities*, it appears that the responsibilities of public agencies to protect others from second-hand smoke outweigh any putative 'right to smoke'. I think that the smoking bans *engage* the rights set out the Charter, but do not *enliven* them.[2]
>
> In *R (on the application of G and others) v Nottinghamshire Healthcare NHS Trust and the Secretary of State for Health*, the majority of the House of Lords found that in a secure mental health facility, 'smoking was not sufficiently connected to the integrity of a person's identity to qualify as an activity meriting the protection of the right to private life' in such a context.[3]
>
> See http://hrlc.org.au/smoke-free-hospital-policy-upheld-by-the-new-zealand-high-court/ which sets out at para 2 of the Commentary section, that the proportionality test under the charter is likely satisfied. I think the evidence about passive smoking is suitably compelling to support a total rather than partial ban. This case dismissed a 'right to smoke' in a NZ hospital.
>
> Against this, in an appeal against a UK secure hospital smoking ban (http://hrlc.org.au/smoking-bans-can-breach-human-rights/) it was found

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2 Emphasis in original.

3 The substance of what appears as a quote is in fact from *R (on the application of N) v Secretary of State for Health* [2009] HRLR 31 [49], which was the appeal from the cited decision found at [2008] HRLR 42.

> that a smoking ban covering grounds constituted discrimination contrary to the European Human Rights Act.
>
> Once more, I think there is strong evidence that partial bans expose non-smoking staff and patients to second-hand smoke and reduce effectiveness compared to a total ban. I would push strongly the duty of the employer to restrict exposure to second-hand smoke to all, and the evidence that a partial ban does not do this, and renders the ban ineffective.

On 26 August 2014, Dr Magner forwarded Dr Sullivan's email to senior members of the Breathe Easy Smoke Free Steering Committee.

44 In August 2014, Dr Magner reported to the defendant's Council that the Breathe Easy Smoke Free Steering Committee was looking at the Charter in relation to the decision to go smoke free.

45 On 2 September 2014, Dr Magner deposes that 'the Committee considered the human rights issues of going smoke free with the benefit of Dr Sullivan's views … the Committee considered that the policy could proceed in a way that was consistent with human rights.'

46 In September 2014, Dr Sullivan's paper, 'Smoking Bans in Secure Psychiatric Hospitals and Prisons' was published in the 'Journal of Law and Medicine'.

47 Updates to the defendant's Executive and Council in October 2014 noted that the Smoke Free Policy had been revised and reviewed by the executive and legal teams.

48 By letter dated 24 October 2014 to all staff, the Chief Executive Officer announced a staff support program, a dedicated noticeboard and an updated intranet site. All staff were encouraged to support their patients to quit prior to 1 July 2015. A similar letter was included in the November publication of 'Family & Friends News' that was distributed to carers and family members, and feedback and questions were invited.

49 By letter dated 27 October 2014 to the Chief Executive Officer, Ms Julie Dempsey, a consumer consultant, set out patients' concerns arising out of the proposed smoking ban. In my opinion the letter and the defendant's response are important features of the defendant's proper consideration and I set them out in full:

This letter is written on behalf of concerned patients at Thomas Embling Hospital about the impending smoking bans coming into force on July 1st 2015. The overall content and individual points raised are a direct reflection of many patients views canvassed from across the hospital.

A key issue around the smoking bans is that it takes away basic human rights of patients. They are not in a prison setting, and are here for treatment, not punishment, thus do not deserve to have this life choice taken away from them.

Many patients see Thomas Embling Hospital as their home, being here for many years, and argue that elsewhere in the general community citizens are not told/forced to quit smoking in their personal place of residence. Even though smoking is banned in a lot of public and government facilities smokers still have the choice to go outside to smoke, many patients here do not have the option to simply walk outside the hospital.

For those who can temporarily leave the hospital and choose to smoke whilst on leave, they are then subjected to involuntary withdrawal every time they are back in this environment. Arguments that say once the first few months of smoking cessation are tackled it becomes easier to handle do not fit with smoker's experience of dealing with this highly addictive habit. In the community it can take numerous attempts to successfully quit and cravings can last decades.

The point was also raised that those patients who do have leave may abscond rather than coming back to such a restrictive/limiting environment, even though the Mental Health Act 2014 outlines in Section 11 that patients should be treated in the least restrictive manner possible. Also those patients, who do progress back to the general community where they can freely smoke, may not report breakthrough symptoms readily to supervising staff for fear of being put back in hospital. This could lead to a more serious episode not being averted by early intervention.

Within the hospital there is also the risk of increased acuity and violence from the stress of forced withdrawal from cigarettes. Nicotine Replacement Therapies have a reputation of giving some people 'night terrors' that can trigger trauma and symptoms of their illness. Quitting abruptly may exacerbate psychological harm for individuals. Patients have a certain vulnerability in this environment and use cigarettes as a positive tool for managing mood and taking 'time-out', which helps to prevent escalation into potential incidents.

Smoking is one of the last luxuries patients have, being forced to quit drugs and alcohol whilst here. There is a very high incidence of past substance abuse amongst the patient population. Smoking helps patients deal with the social isolation experienced at [the Hospital], replacing systems used in the general community to engage in a contributing life. For example, access to sporting clubs for fitness, a regular job to combat boredom and enhance citizenship and identity, and consuming alcohol as an accepted part of social activity and engagement with others.

In fact, the smoke-free policy is not an accepted expectation in the general community, smoking is not illegal. The patients here are a vulnerable group, with restricted rights, who cannot just leave if they are unhappy with the

conditions, and as such are being discriminated against as a minority group. Their privacy will be further invaded with the need for more strip searches and searches of property in an effort to control contraband. They have been afforded no choice and no options. If patients are caught smoking or with associated contraband they face potential loss of leaves and privileges. These conditions contraindicate liberties set out in the Equal Opportunity Act 2010 for direct and indirect discrimination and the Victorian Charter of Human Rights and Responsibilities 2006.

This is the opposite of Recovery Principles as outlined in the NSQHS Accreditation Standards and numerous Government Recovery focussed documents. The argument that smoking bans are part of a 'duty of care' is patriarchal and goes against the Recovery direction underpinning the new MHA 2014. It does not allow for self-determination and autonomy, or a patients' right to make what others may consider 'wrong' or 'bad' choices as outlined in section 11 of the MHA 2014: '(d) persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk;'. This un-inclusive approach can further reinforce patients feeling of disempowerment, hopelessness, and being distanced and stigmatized in contrast to the general community. Many smokers are aware of the health risks and have even offered to sign a waiver against suing the Government should they incur smoking related illnesses.

In fact, the short-term effects of quitting can actually cause harm such as increased stress levels, flashbacks, vivid dreams, significant weight gain, thought disorders like obsessions and pre-occupation and taking up an alternative addiction, e.g. alcohol and illicit drugs. Longer-term effects can involve depression and the need for more psychiatric medication with its potential negative side effects compounding primary health issues further.

Along Recovery lines we propose an alternative course of action to Smoking Bans. There is a strong view held by both smokers and some non-smokers/reformed smokers that people should be encouraged to quit in their own time and way, not by force. On 'personal choice' terms, not 'Forensicare' terms.

Recent research on smoke free policies has shown that models which use total bans have resulted in increased aggression and use of seclusion. Whereas models using designated smoking areas incorporating smoking reduction and cessation plans have had least impact on Occupational, Health and Safety issues. In research outlined by Indigo Daya in her article '"Smoke-Free" at Inpatient Mental Health Facilities: Risks and Issues from a Consumer Perspective', Indigo notes that specific risks and the overall risk levels for services is high in smoking-ban environments compared to designated smoking area environments (See Risk Matrix page 4).

Possible alternatives at [the Hospital] could include designated areas in the current weatherproof 'smoking rooms' on Units at no extra cost. Banning smoking in all other areas including on Campus, in Units or Unit Courtyards would prevent the problem of second-hand and passive smoking. On Canning Unit they already ration cigarettes by the hour. The introduction of this system more broadly would mean that patients would not need to hold their personal cigarette supply. This would reduce opportunities for stand-over tactics by other patients and illegal bartering in relation to tobacco. A smoking reduction

> plan potentially leading to an eventual smoking cessation plan may be helpful to those who feel ready to attempt quitting.
>
> Could you please consider the arguments stated above and allow patients their natural rights to continue smoking, in designated areas within Thomas Embling Hospital?

The letter had attached pages with 46 signatures of patients endorsing the content of the letter.

50 By letter dated 18 February 2015 to Ms Dempsey, the Chief Executive Officer and Chair of the Council of the defendant replied to her letter as follows:

> Thank you for your letter to the CEO and the Chair of the Board, which outlines the concerns of some patients at Thomas Embling Hospital about the impending smoke-free policy that comes into force on 1 July 2015.
>
> As you are no doubt aware, the process of implementing a smoke-free policy is challenging and involves the balancing of a number of competing rights and interests. Forensicare, through the Breathe Easy Project, is committed to a comprehensive consultation and implementation process that carefully considers the impact of the policy on all those to be affected. I have passed your letter the Breathe Easy Steering Committee so that the points you raise can be considered when implementing the policy.
>
> In introducing the policy, Forensicare recognises that smoking is a serious addiction and that quitting smoking can be very challenging, particularly in a long term residential facility such as Thomas Embling Hospital. However, Forensicare recognises its responsibility for the physical wellbeing, as well as the mental health of its consumers, and is committed to addressing the significant life expectancy gap between mental health consumers and the general population. The serious, negative effects of smoking and cigarette smoke on health are well established and the rates of smoking by mental health consumers is a significant factor in their poor health outcomes.
>
> In deciding to make Forensicare a smoke-free environment, Forensicare appreciates the potential impact of quitting smoking on patients' mental and physical health in both the short and long-term. These impacts have been taken into consideration when developing the policy and are reflected in the measures that have been put in place to support patients to quit smoking. Forensicare recognises that nicotine-dependent patients will need to be provided with significant support, both in the months leading up to the implementation of the policy and once the policy comes into effect.
>
> I note your comments regarding the benefits of implementing a partial rather than total smoking ban. In coming to the decision to implement a total ban, the Breathe Easy Steering Committee considered the viability of a partial ban but decided that it would not be appropriate or workable. There is strong evidence that partial smoke-free policies are less successful than total smoke-free policies and create additional problems, the most significant being their limited impact on the culture of smoking, and the potential for conflict between patients, and

> between staff and patients, that could result from inconsistent decisions about access to the smoking area. There is also strong evidence that there is no safe level of second-hand smoke which makes a partial ban difficult to support.
>
> Thank you once again for your letter and for your support of the patients on this issue.

51 On 13 November 2014, Dr Magner was provided with a paper written by the defendant's corporate lawyer discussing the legal risks of implementation of the Smoke Free Policy ('the legal risks paper'). The paper focused on a number of potential challenges to the policy, but with respect to the Charter identified the most relevant rights that may be engaged as:

(a) the right to privacy under s 13;

(b) the rights of patients to humane treatment when deprived of liberty under s 22;[4]

(c) the rights of patients to protection from torture and cruel, inhuman or degrading treatment under s 10;

(d) the right to recognition and equality before the law under s 8; and

(e) the right to life under s 9.

After considering a number of relevant authorities it notes, with respect to the Charter, the following implications for the defendant:

> There are a number of rights under the Victorian Charter of Human Rights which could be argued to be engaged by the smoke-free policy. Additionally, although unsuccessful in the New Zealand case, there may be scope to argue that there are less restrictive means reasonably available to achieve the purposes of encouraging smoking cessation and protecting patients, staff and passers-by from the effects of smoke inhalation. One such example may be the imposition of a partial ban, with allocated outdoor smoking areas within the grounds of Thomas Embling Hospital.
>
> However, any challenge on these grounds would need to overcome the proportionality test in section 7(2) of the Charter which allows rights to be subject to reasonable limitations. Just because a human right is engaged by a

[4] The legal risks paper refers to s 20 of the Charter in respect of 'rights of patients to humane treatment when deprived of liberty' but I accept the defendant's submission that this is a typographical error and it was intended to be a reference to s 22.

> decision or action does not mean that the decision or action is incompatible with the Charter. Rather, a decision is still compatible with the Charter as long as it can be demonstrated that the limitation on the right is reasonable. In relation to a decision to introduce a smoke-free policy, it will be difficult to overcome the proportionality test, given the strong evidence on the harm caused by smoking (including evidence that there is no safe level of secondhand smoke), particularly amongst psychiatric patients, and the strong move towards smoke-free environments expressed in Government policy. There is also strong evidence that partial smoke-free policies are less successful than total smoke-free policies and create additional problems, the most significant being their 'limited impact on the staff and patient culture of smoking', as well as 'equity concerns about access to smoking' stemming from inconsistency of policy application leading to staff conflict with other staff and patients, and patient with other patients.
>
> Regardless of whether or not it could be successfully argued that a particular right was engaged by the smoke-free policy and that the limitation on the right was unreasonable, any action under the Charter would also involve an examination of the consultation and implementation process undertaken by Forensicare. In particular, so as not to be found in breach of its obligations under the Charter, Forensicare would need to demonstrate that it has met its obligation to give proper consideration to relevant rights at every stage of the decision-making process. This would require evidence that Forensicare has considered the various rights that may be impacted by the policy, whether or not the policy is limiting a right in the Charter, and whether the limitation is lawful, necessary, and proportionate in the circumstances.

52 In December 2014, the Smoke Free Policy was approved for publication by the defendant's Policy and Procedure Committee, and was published to staff on 18 December 2014.

53 At the meeting of the Breathe Easy Smoke Free Steering Committee held on 27 January 2015, the defendant's corporate lawyer attended and there was a detailed discussion of issues raised in the legal risks paper. Relevantly, the corporate lawyer noted:

(a) the paper had been written without knowing what processes had been undertaken;

(b) the committee needed to ensure that all rights in the Charter had been looked at and considered; and

(c) the committee discussed sharing the paper with the Consumer Advisory Group, however, thought that the article prepared by Dr Sullivan may be more suitable.

54 At the meeting of the Breathe Easy Smoke Free Steering Committee held on 10 February 2015, the Contraband Policy was amended to make cigarettes, tobacco, electronic cigarettes and other 'smoking paraphernalia' contraband.

55 At the meeting of the Breathe Easy Smoke Free Steering Committee held on 24 February 2015, committee members were strongly encouraged to read the legal risks paper provided by the corporate lawyer.

56 On 27 February 2015, the revised Smoke Free Policy as approved by the Policy and Procedure Committee was published to staff. The overview and purpose in the Smoke Free Policy were stated to be as follows:

> Forensicare is committed to addressing the significant life expectancy gap between mental health consumers and Australia's general population. The serious, negative effects of smoking and cigarette smoke on health are well established. The high rates of smoking by mental health consumers is a significant factor in their poor health outcomes. Forensicare recognises its responsibility for the physical wellbeing, as well as the mental health of its consumers and their families and carers.
>
> Under the Victorian Occupational Health & Safety Act 2004, Section 21, Forensicare is required 'to provide and maintain … a working environment that is safe and without risk to health'. In addition to this requirement, under section 25, employees have a legislated duty of care to ensure and maintain a safe and healthy workplace for their colleagues.
>
> Forensicare recognises that smoking is a serious addiction and that quitting smoking can be very challenging. Quitting smoking is likely to involve particular challenges in a long term residential facility such as the Thomas Embling Hospital.
>
> In deciding to make Forensicare a smoke-free environment, Forensicare believes that mental health consumers can quit smoking if they are given the right support. Forensicare is committed to providing the necessary support to consumers and staff to implement a smoke-free environment, recognising the significant health benefits that will result.
>
> This policy is also consistent with Corrections Victoria's decision to implement a smoke-free policy at all prison sites.
>
> Smoking will not be permitted on any Forensicare site from 1 July 2015.

The document referenced the 'Human Rights Charter' 's 22 — humane treatment when deprived of liberty'.

57 On 30 March 2015, the Chief Executive Officer and Dr Magner attended a meeting of the Consumer Advisory Group to respond to the concerns expressed on behalf of a number of patients opposing the Smoke Free Policy. The patients raised their dissatisfaction with the Smoke Free Policy on the basis of unfairness, discrimination and a restriction of civil liberties. One of the central concerns expressed by the patients was a likely increase in aggression following the ban.

58 On 30 March 2015, medical staff members were given a smoking cessation seminar by Dr Di Kirby, consultant psychiatrist, addiction specialist and tobacco treatment specialist with the Substance Use and Mental Illness Treatment Team at Northwest Mental Health.

59 On 24 April 2015, the Hospital conducted a patient event called the 'Fresh Air Fair' which provided patients and staff with a practical opportunity to examine a range of strategies and resources to help manage withdrawal from nicotine. On the same day, Dr Magner provided all Hospital unit managers with a smoking cessation presentation tailored to the Hospital for the purpose of training them to be able to conduct their own training sessions for staff and patients in their units.

60 In April 2015, Dr Magner reported to the defendant's Council about the activity designed to support patients in withdrawal in each unit of the Hospital.

61 In May 2015, the Dr Magner received a copy of a letter from the Minister for Mental Health dated 19 February 2015 and a copy of a letter from the Minister for Health dated 14 March 2015, each replying to a letter from Ms Dempsey, a consumer consultant, raising concerns raised by patients about the implementation of the Smoke Free Policy. Both letters express support for the Smoke Free Policy.

62 On 4 May 2015, the Dr Magner attended a meeting of the Consumer Advisory Group and responded to patients' concerns about quitting smoking.

63 In May 2015, the Smoking Cessation Support Procedure was approved by the Policy and Procedure Committee and was published to staff on 8 May 2015. The procedures were set out as follows:

> **1. Nicotine Replacement Therapy (NRT)**
>
> Patches, lozenges and gum are the only form of NRT being offered by Forensicare. Whilst other forms of NRT are available over the counter and through the Pharmaceutical Benefits Scheme, the use of such other forms of NRT on Forensicare sites is not permitted - in line with the *Contraband Items Policy*.
>
> **Patients**
>
> Prior to commencing NRT, patients will be physically assessed by their Unit Registrar and if required a referral made to the GP. All smokers will be offered 26 weeks of NRT based on the algorithm found on the Breathe Easy Sharepoint site (refer *Supporting smoking cessation: a guide for health professionals* Treatment guidelines). Options available to patients include patches, lozenges and gum. Requests for alternative quitting pharmacotherapies are considered on a case-by-case basis.
>
> All patients receiving NRT should be reviewed every three months by the Unit Registrar. New patients after July 1, 2015, will be eligible to receive 26 weeks supply of patches and lozenges. Staff preparing patients for escorted leave should review the patient's NRT requirements.
>
> **Staff**
>
> All staff may access free NRT. Free patches and lozenges will be provided for 12 weeks, twice per year for two years from November 1, 2014. To access this offer, staff should complete the form, *Employee Application for Nicotine Replacement Therapy* and submit to the HR officer who will process the request.
>
> More information can be found at www.quit.org.au
>
> **2. Quitline**
>
> All staff and patients who are smokers should be encouraged to use Quitline regardless of the method they choose to use to cease smoking.
>
> Calls to Quitline from Thomas Embling Hospital phones are free of charge for all patients. In line with Forensicare policy, appropriate support is provided to patients who may need assistance to access Quitline.
>
> Patients who identify as Aboriginal and Torres Strait Islander may request an Aboriginal Quitline counsellor.
>
> Quitline referral sheets are available on the Forensicare intranet and at www.quit.org.au

3. Group programs and quitting information seminars

Group programs and information seminars are open to patients, staff, contractors and volunteers and are run by Forensicare smoking cessation specialists. Information about current groups and seminars are available on the Unit noticeboards, the Breathe Easy Noticeboard and the intranet.

4. Other cessation support options

Forensicare recognises that staff may choose to access face to face support via their GP, local Community Health Service Quit Educator, or EAP counsellor.

Written cessation support materials are available on all units.

5. Electronic cigarettes (e-cigarettes)

E-cigarettes are not considered a valid cessation tool due to insufficient scientific evidence regarding their safety and efficacy. Their use on Forensicare sites is not permitted - in line with the *Contraband Items Policy*.

The document referenced the 'Human Rights Charter' 's 22 - humane treatment when deprived of liberty'.

64 On 28 May 2015, the Hospital hosted an event for patients, staff, families and carers called 'No ifs, no butts, share your quitting story'.

65 On the same day, the defendant was notified that the Minister had approved the removal of exemptions of designated areas in five units at the Hospital under the *Tobacco Act*, as had been requested by Dr Magner, effective 1 July 2015.

66 On 29 May 2015, all doctors were issued with a guideline, 'Medication — Clozapine and Smoking Cessation Thomas Embling Hospital Guideline' ('the Clozapine Guideline'). The Clozapine Guideline was formally approved by the Policy and Procedure Committee on 10 June 2015 and was intended to supplement previous general guidance given to doctors on medication changes that might be necessary once smoking was discontinued. With respect to patients who continued smoking on leave, it provided:

> Intermittent smoking during leave may result in fluctuations in serum clozapine levels. The impact of these may not be apparent for several weeks. Discussion and education to be provided to the patient in relation to the

> implications of intermittent smoking on their clozapine levels and impact on cravings. If complete abstinence is not feasible, it may be possible to minimise the fluctuations by agreeing on a set amount of cigarettes smoked per leave.

The Clozapine Guideline referenced 'Human Rights Charter' 'S10 Protection from torture and cruel, inhuman or degrading treatment and medical or scientific experimentation or treatment without consents'.

67 On 2 June 2015, the Contraband Policy, as approved, was published to staff. The Contraband Policy referenced the 'Human Rights Charter' s 13 'Privacy and reputation'; s 22 'Humane treatment when deprived of liberty'; and s 15 'Freedom'.

68 On 17 June 2015, a letter was sent to each patient informing them that the Smoke Free Policy was to be implemented on 1 July 2015 and inviting their feedback. The letter stated:

> Studies have shown there is a significant life expectancy gap between mental health consumers and Australia's general population as well as high rates of smoking by mental health consumers which is having a significant impact on health outcomes.

It also noted:

> Forensicare recognises smoking is a serious addiction and quitting can be very challenging.

As a result, the letter confirmed that nicotine replacement therapy and support would be available for up to six months. On the same day, a similar letter was sent to each carer.

69 By email dated 18 June 2015 to all Hospital staff, Dr Magner confirmed that smoking would not be permitted on escorted leave from 1 July 2015, and confirmed that 'Forensicare is committed to a therapeutic management of any breach of its Smoke Free policy'.

70 By 23 June 2015, all patients were expected to have an individual smoking management plan in place.

71 On 25 June 2015, the Fresh Air Fair was repeated at the Hospital.

72 On 16 June 2015, the Chief Executive Officer and the defendant's corporate lawyer met with the plaintiff's brother to discuss his concerns about the Smoke Free Policy. One of his concerns was the issue of the plaintiff continuing to smoke while on unescorted day leave; but having to dispose of his cigarettes on return to the Hospital. As a result, at its meeting on 17 June 2015, the defendant's Executive decided it would be prepared to consider storing smoking related contraband for patients with unescorted leave.

73 On 29 June 2015, the defendant gave an undertaking not to implement the Smoke Free Policy in the Jardine Unit of the Hospital pending the hearing and determination of this proceeding.

Is the Smoke Free Policy beyond the power of the defendant in that it falls outside the powers given to it by the *Mental Health Act 2014?*

74 The defendant was established on 1 January 1998 under s 117B of the *Mental Health Act 1986* and is continued under s 328 of the *Mental Health Act 2014* ('the Act'). Under s 331(1) of the Act, it is empowered to 'do all things that are necessary or convenient to be done for, or in connection with, or as incidental to, the performance of its functions.' Section 330 sets out the functions of the defendant, including:

> (a) to provide, promote and assist in the provision of forensic mental health and related services in Victoria;
>
> …
>
> (h) to promote continuous improvements and innovations in the provision of forensic mental health and related services in Victoria.

Plaintiff's submissions

75 It was submitted on behalf of the plaintiff that the Smoke Free Policy was outside the powers of the defendant because it was not 'done for, or in connection with, or as incidental to' the provision of mental health services. In particular, the provision of mental health services was unrelated to where and when residents at the Hospital smoked.

76 The plaintiff submitted this was demonstrated by the fact that the Smoke Free Policy would merely force the plaintiff, for example, to stop smoking on the Hospital premises but it would not prevent him from smoking between 7 am and 9 pm when he left the Hospital grounds on unescorted day leave. Accordingly, it would merely force him to leave the Hospital and the psychological support provided to him within it, in order to continue smoking. Further, if, as a result of a relapse in his mental condition he lost the right to day leave, the Smoke Free Policy would prevent him from engaging in a lawful activity, being smoking, which is unrelated to the provision of mental health services to him.

Defendant's submissions

77 The defendant submitted that the introduction of the Smoke Free Policy was within the powers of the defendant as conferred by s 331 of the Act for the following reasons:

(a) It is for the party asserting a lack of power to make good its claim.[5]

(b) The introductory words of s 331(2) of the Act, namely 'Without limiting the generality of subsection (1)', 'evince an intention that the general power should be given a construction that accords with the width of the language in which it is expressed and that this construction is not to be restricted by reference to the more specific character of that which follows'.[6]

(c) The words 'for, or in connection with, or as incidental to' are words of considerable width and the relevant function '*to provide, promote and assist*' in the provision of forensic mental health *'and related services*'[7] is expressed in broad terms.

(d) The plaintiff's submission is, in effect, that the defendant's powers are limited to things which directly involve the provision of mental health or related

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5 *Hird v Chief Executive Officer of the Australian Spots Anti-Doping Authority* (2015) 227 FCR 95, 158 [209] (Kenny, Besanko and White JJ); *Kathleen Investments (Australia) Ltd v Australian Atomic Energy Commission* (1977) 139 CLR 117, 145–146 (Stephen J), 153–155 (Mason J).

6 *Leon Fink Holdings Pty Ltd v Australian Film Commission* (1979) 141 CLR 672, 679 (Mason J).

7 Emphasis added.

services. This is inconsistent with the broad expression used in the empowering section.

(e) The provision of mental health services should not be limited to the diagnosis and treatment of mental illnesses or disorders affecting individual patients. The Smoke Free Policy forms part of the provision of forensic mental health services at the Hospital.

(f) It is not clear how the fact that the Smoke Free Policy may result in the plaintiff only stopping smoking between 9 pm and 7 am (when he was required to be at the Hospital) relates to the scope of the defendant's power. However, to the extent that it is based on the proposition that the effect of the Smoke Free Policy is to prevent the plaintiff from engaging in the lawful activity of smoking and therefore is unrelated to the provision of mental health services, such proposition is contradicted by the evidence.

(g) The plaintiff's construction of the defendant's powers being so limited ignores the necessity of the defendant exercising a broad range of powers to properly provide mental health and related services at the Hospital such as:

(i) the provision of a safe environment for patients, staff and contractors; and

(ii) the myriad of rules, policies and procedures required to conduct a hospital including policies which restrict the possession of alcohol or dangerous items; or

(iii) any other restriction on the conduct of patients and staff.

78 The defendant further submitted that the introduction of a smoke free policy was incidental to the defendant's function under s 330(h) of the Act 'to promote continuous improvements and innovations in the provision of forensic mental health and related services in Victoria'.

The authorities

79 Recently, in *Hird v Chief Executive Officer of the Australian Sports Anti-doping Authority*,[8] the Full Court of the Federal Court considered the scope of the general power conferred by s 22 of the *Australian Sports Anti-doping Authority Act 2006* (Cth) which provided that 'The CEO has the power to do all things necessary or convenient to be done for or in connection with the performance of his or her functions'. In finding that, despite the absence of any express provision, the section empowered the Australian Sports Anti-Doping Authority to act jointly with the Australian Football League, the Court said as follows:

> The Parliament has commonly used provisions like s 22 of the ASADA Act to ensure that a statutory body has sufficient power to discharge its functions in circumstances that the Parliament could not practically set down, although they lie within the contemplation of its enactment. The authorities that have discussed the scope of a 'necessary' or 'convenient' power such as that in s 22 of the ASADA Act support the general proposition that s 22 is to be construed in conformity 'with the width of the language in which it is expressed': *Leon Fink* at 679 (Mason J; Barwick CJ and Aickin J agreeing). As Ryan J stated in *Anthony Lagoon* at 585, '[t]he language of a grant of power to do "all things necessary or convenient to be done for or in connexion with the performance of" an enumerated list of functions is of considerable width'. (Although Ryan J was in dissent in the result of the case, Sweeney J agreed with this point: 567.) Plainly enough, the scope of a grant of power of this kind should be interpreted in light of the functions that the Parliament has conferred on the body in question: see *Leon Fink* at 677-679; *Kathleen Investments* at 143, 145-146 (Stephen J) and 153-155 (Mason J); *Botany Municipal Council v Federal Airports Corporation* (1992) 175 CLR 453 at 462; and *Anthony Lagoon* at 585 (Ryan J). Where, as here, the legislature confers a function in general terms, a grant of power in the terms of s 22 will, generally speaking, have a commensurably wide scope: *Anthony Lagoon* at 590 (Ryan J) and *Morton v Union Steamship Co of New Zealand Ltd* (1951) 83 CLR 402 at 410.[9]

80 In *B v Waitemata District Health Board*,[10] the applicants challenged a smoke free policy adopted by the respondent with respect to two hospitals operated by it. The applicants contended that the smoke free policy was not within the power of the respondent and it was inconsistent with the *New Zealand Bill of Rights Act 1990*.

81 The respondent was a District Health Board which Asher J held could 'regulate the behaviour and activity of patients, staff and visitors who use and access the sites it

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8 (2015) 227 FCR 95.

9 Ibid 157 [210].

10 [2013] NZHC 1702.

owns or leases, providing it does so consistently with its purposes, objectives and powers … However, it may only do an act for the purpose of performing its functions. It can only do things that fall within the objectives of [District Health Boards] as defined by Parliament in the *New Zealand Public Health and Disability Act 2000*'.[11]

82 The objectives under s 22(1) of that Act included:

> (a) to improve, promote, and protect the health of people and communities;
>
> …
>
> (c) to promote effective care or support for those in need of personal health services or disability support services.

The functions under s 23(1) included 'to promote the reduction of adverse social and environmental effects on the health of people and communities'.[12]

83 Asher J said that the relevant Act did not 'specifically prescribe every action that may be carried out by the [respondent], and its powers must be construed broadly, consistent with the purposes of the Act'.[13]

84 Asher J concluded that the respondent was acting intra vires in instituting the smoke free policy[14] and stated as follows:

> As with any ordinary owner of a site that members of the public visit to obtain services such as a restaurant or a hotel, the WDHB has the right to impose conditions on those who enter its property so long as those restrictions are consistent with its objectives and functions. It may regulate the conduct of those who come on its site, insofar as those restrictions do not impose upon positive rights.
>
> Dr Patton, the WDHB psychiatrist and clinical director of mental health and addiction services, stated in his evidence that there have to be rules associated with getting care. In the hospital setting, it is not acceptable for someone to practice sexual promiscuity, or use alcohol or other substances or medications for their gratification. There is a clear risk posed by such activities for patients, either to themselves or to other people, even if those persons feel distress and that their autonomy is being restricted by not allowing that behaviour.

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11 Ibid [18].
12 Ibid [21]–[22].
13 Ibid [24].
14 Ibid [40].

> Smoking is a recognised and preventable health hazard for New Zealanders. This is rightly not contested by the applicants. The containment and reduction of that hazard in my view falls entirely within the purposes of DHBs to 'improve, promote and protect the health of New Zealanders'. If a DHB bans smoking on its property as a matter of considered policy, it is taking steps to promote the cessation of individual New Zealanders smoking, and thereby protect their health and improve it, and protect others from tobacco smoke. The elimination of passive smoking promotes the same end.
>
> Given that smoking is a health hazard and that DHBs have a duty to promote policies to prevent or restrict health hazards, it is entirely within the powers vested in DHBs for them to have policies to stop smoking. Of course the power is not unlimited. The Act gives a DHB no power to dictate to New Zealanders how they should behave in their own homes or in places over which DHBs have no control even if they are DHB patients. It is to be noted that staff, patients and visitors are not prohibited by the Smoke-free Policy from smoking per se. They must leave the site if they wish to smoke.[15]

85 Similarly, in *CM v State Hospitals Board for Scotland*,[16] the Inner House of the Court of Session in Scotland found that a prohibition on smoking in the buildings and grounds of a state hospital, in which the petitioner was involuntarily detained as a result of his mental condition, was within the ambit of a general power provided under an Act which placed defined 'state hospitals' 'under the control and management' of 'the Ministers', who had delegated the power to the relevant board.[17]

Conclusion

86 I reject the plaintiff's contention that the Smoke Free Policy is beyond the defendant's powers under the Act for the reasons submitted by the defendant. I consider that the Smoke Free Policy is well within the powers of the defendant as conferred by s 331 of the Act particularly for the following reasons:

(a) The issue of whether activities such as smoking and drinking are to be permitted at the Hospital are directly related to the performance of its function of providing mental health services in Victoria.

(b) The limited interpretation of ss 331 and 330(h) as contended for by the plaintiff would be tantamount to saying that the powers of the defendant were limited

15 Ibid [26]–[29].
16 [2014] CSIH 71.
17 Ibid [3], [67].

to matters directly related to medical treatment. This would ignore the need of the defendant to make provision for the myriad things that are required to be regulated, as a matter of practical necessity, for the proper management of a substantial mental hospital.

(c) The words used in empowering section, 'to do all things that are necessary or convenient to be done for, or in connection with, or as incidental to, the performance of its functions', are not consistent with a narrow interpretation of the powers.

(d) A narrow construction of the defendant's powers under s 331 would be inconsistent with the authorities referred to above.

Is the Smoke Free Policy contrary to the *Tobacco Act 1987?*

87 Section 5A(1) of the *Tobacco Act* provides that 'A person must not smoke in an enclosed workplace'. Section 5A(2)(h) provides that sub-s (1) does not apply to 'an area in a designated mental health service (within the meaning of the *Mental Health Act 2014*) that is declared, or that is in a class of area that is declared, by the Secretary [of the Department of Health], by notice published in the Government Gazette, to be a smoking area'. Until 1 July 2015, there was a declaration in force under s 5A(2)(h) in relation to certain 'glass partition rooms' adjacent to the secure courtyard in each of the five units within the high security perimeter at the Hospital. Accordingly, the prohibition on smoking in an enclosed workplace did not apply in those declared areas. However, from 1 July 2015, the declaration under s 5A(2)(h) was revoked consistent with the Smoke Free Policy.

Plaintiff's submissions

88 The plaintiff submitted that the fact that, under the *Tobacco Act*, smoking was not prohibited in the outdoor areas of the Hospital, effectively recognised that there was a right to smoke in those areas. In support of this contention, the plaintiff referred to the fact that, for the purpose of prohibiting smoking in prisons, the *Corrections*

Amendment (Smoke-Free Prisons) Act 2014 repealed the provision in s 5A(2) by which parts of prisons could be exempted from the prohibition on smoking in an enclosed workplace.[18]

89 The plaintiff submitted that, as Parliament did not repeal s 5A(2)(h), it reserved to itself the power to reinstate the exemption in enclosed workplaces for any part of the Hospital buildings.

90 Accordingly, the plaintiff contended that the right to smoke in the outdoor areas of the Hospital is a fundamental right which can only be removed by Parliament through legislation on the basis of the following argument:

(a) The preamble to the *Tobacco Act* provides as follows:

> Whereas—
>
> (a) the following guiding principles are recognised in relation to the use, supply and promotion of tobacco—
>
> (i) tobacco use is so injurious to the health of both smokers and non-smokers as to warrant restrictive legislation;
>
> (ii) tobacco use has adverse health effects even with infrequent use and there is no completely safe form of tobacco use;
>
> (iii) tobacco use is a widely accepted practice amongst adults which it is inappropriate to ban completely;
>
> (iv) the extent of the health effects of smoking requires strong action to deter people from taking up smoking and to encourage existing smokers to give up smoking;
>
> (v) the association of smoking with social success, business advancement and sporting prowess through use of advertising and promotion has a particularly harmful effect by encouraging children and young people to take up smoking; and
>
> (b) it has been resolved to discourage the use of tobacco in all its forms and to prohibit various types of promotion and advertising of tobacco products in order to reduce the incidence of tobacco-related illness and death.

[18] See s 7 which repealed sub-s 5A(2)(i) of the *Tobacco Act*.

(b) The purpose of the Act under s 1 'is to prohibit certain sales or promotion of tobacco products and certain non-tobacco products, to create offences in relation to smoking and the possession of tobacco products and to establish the Victorian Health Promotion Foundation'.

(c) Implicitly, the preamble recognises that people have a right to smoke and these provisions give a 'statutory imprimatur' or statutory right, which elevates the right to smoke that did exist prior to the *Tobacco Act* to that of a fundamental right.

(d) The effect of the statutory imprimatur is that it gives the right to smoke sufficient significance to invoke the presumption of legality. Statutory rights were recognised as giving rise to the presumption of legality by Finn J in *Buck v Comcare*,[19] where his Honour said of an employee's right under the *Safety, Rehabilitation and Compensation Act 1988* (Cth):

> that right does not fall into the category of 'common law' rights which traditionally have been safeguarded from legislative interference etc in the absence of clear and unambiguous statutory language. Yet it is a right of sufficient significance to the individual in my view, that, where there may be doubt as to Parliament's intention, the court should favour an interpretation which safeguards the individual. To confine our interpretative safeguards to the protection of 'fundamental common law rights' is to ignore that we live in an age of statutes and that it is a statute which, more often than not, provides the rights necessary to secure the basic amenities of life in modern society'.[20]

91 Accordingly, it was submitted that as the *Tobacco Act* implicitly recognised a statutory right to smoke, and because under s 5A it reserved the power to itself to prohibit smoking, the right to smoke could only be removed by a clear expression of an intention by the Parliament, as it had done with respect to prisons.

Defendant's submissions

92 The defendant submitted that the *Tobacco Act* did not create or confer any positive right to smoke and referred to the following provisions in that Act:

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19 (1996) 66 FCR 359 (citation omitted).

20 Ibid 364–5.

(a) While the guiding principles in the Preamble accept that 'tobacco use is a widely accepted practice amongst adults which it is inappropriate to ban completely', those principles also recognise that 'tobacco use is so injurious to the health of both smokers and non-smokers as to warrant restrictive legislation' and that 'the extent of the health effects of smoking requires strong action to deter people from taking up smoking and to encourage existing smokers to give up smoking'. Further, the Parliament resolves 'to discourage the use of tobacco in all its forms'.

(b) The statutory purpose in s 1 relevantly includes the creation of offences in relation to smoking - which is vastly different to creating rights to smoke.

(c) The statutory objects in s 5 include 'the active discouragement of the smoking of tobacco' and 'the promotion of health and illness prevention', and to give effect to these objects the Minister is to cause steps to be taken 'to encourage agreements to prohibit or limit the places and times at which people may smoke in enclosed public places or in the work environment'.

Accordingly, it submitted that an absence of prohibition under the *Tobacco Act* should not be equated with the conferral of a positive right to smoke.

93 The defendant further submitted that the fact that Parliament repealed the exception under s 5A(2)(i) of the *Tobacco Act* in relation to smoking in prisons, does not indicate any legislative intention that smoking should be permitted unless it is legislatively prohibited for the following reasons.

(a) The express purposes set out in s 1 of the *Corrections Amendment (Smoke-Free Prisons) Act 2014* including 'to remove the exception relating to prison cells and exercise yards from the offence of smoking in an enclosed workplace' does not support a legislative intention to otherwise permit smoking in other contexts or locations.

(b) The fact that s 5A(2)(h) has not been removed and there is a possibility of further declaration being made by the Secretary of the Department of Health ('the Secretary') does not indicate that the Parliament has reserved to itself the power to prohibit smoking in enclosed workplaces; and, in fact, the power is conferred on the Secretary.

(c) The fact is that the power has not been exercised by the Secretary and therefore no inconsistency arises.

(d) Even if the Secretary was to declare specified areas within the Hospital to be exempt from the prohibition on smoking imposed by s 5A of the *Tobacco Act,* it would not be clear that such an exemption would override a smoke free policy imposed by the defendant acting within its statutory powers of management of the Hospital.

Conclusion

94 The plaintiff has a right to smoke in the sense that he has a right to 'do what he pleases, provided he does not transgress the substantive law, or infringe the legal rights of others'.[21] However, I reject the plaintiff's submission based on the *Tobacco Act* substantially for the reasons submitted by the defendant. Specifically, I consider that the *Tobacco Act* could not be properly read as intending to create, expressly or implicitly, a statutory right to smoke. To the extent that the *Tobacco Act* does not prohibit smoking, I do not consider that such a lack of prohibition could override a properly exercised power, in this case under the *Mental Health Act 2014*, to adopt a smoke free policy.

95 The plaintiff did not identify whether the purported 'statutory right' arising from the fact there was no prohibition on smoking under the *Tobacco Act* would override the right of an occupier of premises to prohibit smoking. It is not clear why, if such a principle did exist, it would not extend to private homes and all external places open to the public. In my opinion, a proper reading of the *Tobacco Act,* and in particular its preamble, demonstrates an intention to discourage smoking, which is inconsistent with the plaintiff's submission that it gives rise to a statutory right to smoke. I consider the submission, that the Parliament intended by the *Tobacco Act* to reserve exclusively to itself the power to control smoking in the workplace, is misconceived.

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[21] *Halsbury's Laws of England* (Butterworths, 1954) vol 7, 195–6 cited with approval in *Antunovic v Dawson* (2010) 30 VR 355, 359 [7] (Bell J).

Did the defendant contravene the *Charter of Human Rights and Responsibilities Act 2006*?

96 The plaintiff contended that the defendant had acted unlawfully, in contravention of s 38 of the Charter, by implementing the Smoke Free Policy without giving proper consideration to relevant human rights. Section 38(1) of the Charter provides:

> Subject to this section, it is unlawful for a public authority to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right.

97 There was no issue that the defendant was a public authority for the purposes of the Charter and the plaintiff submitted that the Smoke Free Policy engaged the following human rights:

(i) Section 22(1) which relevantly provides that:

> All persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.

(ii) Section 10(c) which relevantly provides that:

> A person must not be … subjected to medical … treatment without his or her full, free and informed consent.

(iii) Section 22(3) which relevantly provides that:

> …a person detained without charge must be treated in a way that is appropriate for a person who has not been convicted.

98 The plaintiff also contended that the defendant may contravene s 20 which relevantly provides that:

> A person must not be deprived of his or her property other than in accordance with law.

This was based on the fact that the Smoke Free Policy provides that cigarettes will be managed in accordance with the defendant's Contraband Policy, which would result in cigarettes being confiscated. In particular, when the plaintiff would return to the Hospital after day leave, his cigarettes would be taken from him and destroyed. However, the evidence disclosed that no decision had yet been made about whether confiscated cigarettes would be returned to the plaintiff on leaving the Hospital; and

accordingly, it was premature to decide whether the plaintiff's right under s 20 has been engaged. The plaintiff will be given leave to make this application after the defendant has made a relevant decision.

The scheme of the Charter

99 Pursuant to s 38(1) of the Charter it is unlawful for a public authority:

(a) to act in a way that is incompatible with a human right ('the substantive requirement'); or

(b) in making a decision, to fail to give proper consideration to a relevant human right ('the procedural requirement').

100 An act of a public authority will be 'incompatible with a human right' if it limits the relevant human right in a manner which is not reasonable and demonstrably justified as set out in s 7(2) of the Charter.[22]

101 Section 7(2) provides as follows:

> A human right may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom, and taking into account all relevant factors including—
>
> (a) the nature of the right; and
>
> (b) the importance of the purpose of the limitation; and
>
> (c) the nature and extent of the limitation; and
>
> (d) the relationship between the limitation and its purpose; and
>
> (e) any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

However, the plaintiff does not allege in this case that the defendant has acted incompatibly with a human right and therefore it is not necessary to consider s 7(2).

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22 *PJB v Melbourne Health (Patrick's case)* (2011) 39 VR 373, 441–2 [310] (Bell J) ('*Patrick's case*'); *R v Momcilovic* (2010) 25 VR 436, 475 [144] (Maxwell P, Ashley and Neave JJA).

102 The plaintiff only alleges that the defendant has contravened the procedural requirement by failing to give proper consideration to the specified human rights in making the decision to implement the Smoke Free Policy. For the defendant to be required to give proper consideration to human rights under s 38(1), such rights must be 'relevant'. Human rights will be relevant if the proposed decision will apparently limit such rights. A decision, which will apparently limit a right (without consideration of s 7(2) factors), is said to have 'engaged' the right. Engagement, in this sense, is to be contrasted with 'incompatibility', which applies when the limitation of the right cannot be demonstrably justified according to s 7(2).[23]

103 In *Kracke v Mental Health Review Board*,[24] Bell J explained that it was preferable to speak of the 'engagement' of a human right rather than a 'breach' or 'infringement' of the human right because the latter terms would be more appropriate if the engagement has been found not to be reasonable or demonstrably justifiable under s 7.[25] Accordingly, the term 'engagement' of a human right means that the act or decision in question 'prima facie imposes a limit that needs to be justified under s 7(2) so that, if it is justified, the provision will be compatible with human rights'.[26]

104 Accordingly, to determine whether the defendant has breached the procedural requirement, it is necessary to determine:

(1) whether the Smoke Free Policy did engage each of the specified human rights;[27] and if so

(2) whether, in making the decision, it failed to give proper consideration to the relevant human right.

I will consider each of the human rights the plaintiff submitted have been engaged in turn.

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23 *Antunovic v Dawson* (2010) 30 VR 355, 371 [70] (Bell J).

24 (2009) 29 VAR 1, 27 [67].

25 Ibid. As Bell J said: 'Even then, under the Charter, incompatible is the more exact description' of the act or decision made unlawful under s 38(1) than 'breach', 'violation' or 'infringement'.

26 Ibid 27 [67].

27 *Castles v Secretary of the Department of Justice* (2010) 28 VR 141, 155 [45] (Emerton J) ('*Castles' case*').

The dignity right

105 Section 22(1) provides:

> All persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.

106 In this case, there was no issue that the plaintiff is a person deprived of his liberty by operation of the custodial supervision order of the Court which requires that he be a resident at the Hospital.

Has the dignity right been engaged?

Plaintiff's submissions

107 The plaintiff contended that the dignity right has been engaged for the following reasons:

(a) The plaintiff is addicted to tobacco smoking and the Smoke Free Policy will require that he is only able to smoke when he is on unescorted visits outside the Hospital, where he is without psychological support. The plaintiff is concerned that being prevented from smoking in this way will cause significant deterioration of his mental state.

(b) If the plaintiff's mental state deteriorates or he otherwise does not continue to take day leave, the Smoke Free Policy will have the effect of forcing him to quit smoking. Given his long term addiction, the consequences of giving up smoking will be as follows:

(i) Withdrawal symptoms which may include irritability, poor concentration, anxiety, restlessness, increased hunger, depressed mood and craving for tobacco - symptoms which may develop within 12 hours and can persist for 3 weeks.

(ii) Nicotine replacement products can cause side effects including gastrointestinal disturbance, headache, dizziness, influenza-like symptoms, dry mouth, rash and palpitations. Nicotine replacement

therapy is not as effective for persons with schizophrenia as for the general population.

(iii) The plaintiff will be without nicotine which relieves boredom and distress; and facilitates social interaction.

(iv) The plaintiff will be without nicotine which, for persons suffering from psychiatric disorders, acts as an antidepressant and gives pleasure.

108 The plaintiff also contended that the Contraband Policy would result in the plaintiff 'binge smoking' when on unescorted leave so as to minimise the number of confiscated cigarettes. As previously indicated, no decision has yet been made that confiscated cigarettes would not be returned and accordingly I put this submission to one side.

Defendant's submissions

109 The defendant submitted that the Smoke Free Policy does not engage the dignity right in s 22(1) for the following reasons:

(a) The plaintiff's concerns about the possibility that the Smoke Free Policy will lead to a deterioration in his mental health are merely concerns and are not based on expert psychiatric or medical opinion.

(b) The plaintiff's submissions failed to recognise that the Smoke Free Policy will be attended by the provision of active support to patients in the form of nicotine replacement options, counselling and access to smoking cessation support specialists.

(c) To the extent that the plaintiff's submissions are based on assertions 'from the literature', they do not give a complete or accurate picture of scientific or medical opinions on the effects of smoking and smoking cessation on mental health.

The Attorney-General's submissions

110 The Attorney-General also submitted that the dignity right was not engaged by the decision to implement the Smoke Free Policy. It was contended that the adverse consequences identified by the plaintiff did not amount to treatment of the plaintiff in a manner that lacked humanity, demeaned the plaintiff or was excessive for the following reasons:

(a) Although it was accepted that the plaintiff may suffer withdrawal symptoms over the short term, such symptoms do not rise to a level of treatment that will engage the dignity right; and nicotine replacement therapy is available to alleviate those symptoms.

(b) Although the plaintiff may (or may not) experience some side effects from the nicotine replacement therapy, the evidence of Dr Magner was that all patients would have an individual smoking management plan put in place and a special nicotine replacement therapy monitoring form was to be included with patients' medication charts. In any event, the side effects of nicotine replacement therapy, it was contended, did not rise to a level that engaged the dignity right.

(c) The removal of an activity that provides pleasure, and relieves boredom and stress does not rise to a level that engages the dignity right. The evidence of Dr Magner was that 'the use of activities and a therapeutic approach has generally been effective in implementing the smoking ban without significant disruption and distress to the patients'.

(d) The evidence of Dr Magner was that cessation of smoking actually improves mental health, and accordingly, smoking was not an appropriate form of self-medication for people with schizophrenia.

(e) The decision to implement the Smoke Free Policy involved extensive consultation with patients and was to be implemented with significant and individualised support. Accordingly, the decision had been implemented

compassionately as would befit the patients, including the plaintiff, as human beings.

The authorities

111 In *Castles v Secretary of the Department of Justice*,[28] Emerton J considered the content of the dignity right in circumstances where a female prisoner was refused leave to continue IVF treatment, which she had commenced prior to her conviction. By the time she would become eligible for home detention, IVF treatment would no longer be available to her. Her Honour considered that 'the starting point should be that prisoners not be subjected to hardship or constraint other than the hardship or constraint that results from the deprivation of liberty'.[29] Her Honour noted that a necessary consequence of the deprivation of liberty was that 'Rights and freedoms which are enjoyed by other citizens will necessarily be "curtailed", "attenuated" and "qualified" merely by reason of the deprivation of liberty'.[30]

112 Emerton J also considered the interaction between dignity right in s 22(1) and the right against inhuman treatment in s 10 of the Charter, which provides as follows:

> A person must not be –
>
> (a) subjected to torture; or
>
> (b) treated or punished in a cruel, inhuman or degrading way; or
>
> (c) subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.

113 Her Honour concluded:

> s 22(1) of the Charter ought not to be conflated with s 10(b), which protects persons from treatment or punishment that is cruel, inhuman or degrading. Section 22(1) is a right enjoyed by persons deprived of their liberty; s 10(b) applies more generally to protect all persons against the worst forms of conduct. Section 10(b) prohibits 'bad conduct' towards any person; s 22(1) mandates 'good conduct' towards people who are detained.[31]

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28 Ibid.

29 Ibid 169 [108].

30 Ibid 170 [111] citing *R (Daly) v Secretary of State for the Home Department* [2001] 2 AC 532, 537 [5] (Bingham LJ).

31 Ibid 167 [99] (citation omitted).

114 In *Taunoa v Attorney-General*,[32] the New Zealand Supreme Court found that a behaviour management regime introduced by the Department of Corrections to manage very difficult and dangerous prisoners constituted a breach of the dignity right (as contained in s 23(5) of the *New Zealand Bill of Rights Act 1990*) but not the right against inhuman treatment (as contained in s 9 of the *New Zealand Bill of Rights Act 1990*). The regime included:

(a) A poor standard of hygiene in the cells with poor natural lighting and sometimes lack of fresh air, unacceptable laundry conditions and unnecessary rationing of toilet paper.

(b) A failure to monitor individual prisoners regularly or assess their mental health.

(c) Inadequate opportunity to exercise, particularly outdoors.

(d) No effective privacy; and incidents where prisoners were left naked or just with a towel after control and restraint techniques were used together with an unlawful practice of routine strip searches with questionable justification.

(e) A lack of rehabilitation programs including deprivation of access to books and television.

(f) Unclear and inadequate information about the operation of the regime.

115 The New Zealand Supreme Court considered, with respect to the treatment of prisoners, the interaction between the dignity right and the right against inhuman treatment. Elias CJ considered that the dignity right was concerned to ensure the prisoners were treated 'humanely', while the right against inhuman treatment was concerned with the prevention of treatment properly characterised as 'inhuman'. Her Honour concluded as follows:

> The concepts are not the same, although they overlap because inhuman treatment will always be inhumane. Inhuman treatment is however different

[32] [2008] 1 NZLR 429 (Blanchard, Tipping, McGrath and Henry JJ with Elias CJ dissenting).

> in quality. It amounts to a denial of humanity. That is I think consistent with modern usage which contrasts 'inhuman' with 'inhumane' … In application to those deprived of liberty, such provisions are based on the fundamental premise that prisoners are not to be treated as if they are less than human. Denial of humanity may occur through deprivation of basic human needs, including personal dignity and physical and mental integrity. Inhuman treatment is treatment that is not fitting for human beings, 'even those behaving badly in prison'.[33]

116 Blanchard J similarly concluded that the right against inhuman treatment in s 9 was 'intended to capture treatment or punishment which is so grossly disproportionate to the circumstances. Conduct so characterised can, in my view, when it occurs in New Zealand, be fairly called "inhuman"'.[34] His Honour continued with respect to the dignity right:

> That leaves to s 23(5) the task, couched as a positive instruction to the New Zealand government, of protecting a person deprived of liberty and therefore particularly vulnerable (including a sentenced prisoner) from conduct which lacks humanity, but falls short of being cruel; which demeans the person, but not to an extent which is degrading; or which is clearly excessive in the circumstances, but not grossly so.[35]

117 Another example of a treatment that was incompatible with the dignity right was considered in *Attorney-General v Udompun*.[36] In that case, the New Zealand Court of Appeal found that Mrs Udompun, who was refused entry to New Zealand and detained for two days while awaiting the next available flight back to Thailand, was not afforded dignity rights during her detention. The contravening conduct was found to arise from a failure to provide her with sanitary products, exacerbated by a failure to give her an opportunity to change her clothes before being taken to the police station, a failure to offer her a shower at the police station and a delay of some 12 hours before providing her with food.[37]

118 Although no Australian cases have considered the effect of a smoking ban on the rights of inpatients at mental hospitals, the issue has been the subject of judicial consideration overseas. Section 32(2) of the Charter provides that 'International law

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33 Ibid 471–2 [79]–[80].
34 Ibid 501 [176].
35 Ibid 501–2 [177] with whom McGrath J agreed 544 [340].
36 [2005] 3 NZLR 204 (McGrath, Glazebrook, Hammond, William Young and O'Regan JJ).
37 Ibid 235–6 [141]–[148] (McGrath, Glazebrook, William Young and O'Regan JJ).

and the judgments of domestic, foreign and international courts and tribunals relevant to a human right may be considered in interpreting a statutory provision'.

119 In 1988, the special position of smoking bans on detainees (in that case, prisoners) was noted in *Carlston v New Brunswick (Solicitor General)*[38] in the New Brunswick Court of Queen's Bench in Carlston, which considered a general policy that banned smoking in all workplaces of the civil service. Dickson J said the following about the application of that policy to prisoners:

> Those concerned with adoption of the non-smoking policy appear to have been slow in recognizing that inmates in a gaol, insofar as smoking practices are concerned, stand in a somewhat different position than do public employees. To inmates the institution in which they are confined is their residence and their temporary home. Unlike employees they cannot step out onto the back stoop for a frequent cigarette, or smoke through a lunch-hour or an evening. At the same time, it must be recognized that for one incarcerated in a gaol, often with little to occupy one's mind or attention, the ability to smoke probably represents a luxury the nature of which it is difficult for one on the outside to appreciate.[39]

Dickson J found that the ban of smoking indoors did not infringe the rights of prisoners not to be subjected to cruel and unusual treatment or punishment under s 12 of the Canadian Charter of Rights and Freedoms. However, he did say that 'had the total ban policy of early April remained in operation and had it been adequately established that the applicant was in fact a smoking addict, I would have had little hesitation in finding that the application of that policy constituted cruel and unusual treatment insofar as the applicant was concerned and that as such it would amount to an infringement of that right to which he is entitled by reasons of s. 12 of the Charter.'[40] This observation was made in obiter, without detailed consideration and may well be indicative of the change in attitudes towards smoking over the past 27 years.

120 As noted in [80] above, in *B v Waitemata District Health Board*[41] an involuntary patient challenged a smoking ban on the basis of a lack of power and as being inconsistent

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38 (1989), 99 N.B.R. (2d) 41 (Q.B.T.D.).
39 Ibid 51 [22].
40 Ibid 49 [16].
41 [2013] NZHC 1702.

with the dignity right under s 23(5) of the *New Zealand Bill of Rights Act 1990*. Asher J rejected the submission that the non-smoking policy affected the dignity right stating:

> In contrast to the harsh detention regime in *Taunoa*, a non-smoking policy is for the long term benefit of the patients, and conducted with humanity with nicotine replacement and other therapies being available to assuage the effects. In that case, Ronald Young J characterised the s 23(5) right as imposing a 'positive duty' to ensure treatment 'as befits a human being with compassion'. The cases in which s 23(5) has been successfully invoked have involved failures by authorities to provide basic human necessities such as sanitary products, bedding and clothing, or where there has been brutish and unnecessary use of police force. I do not consider that refusal to provide smoking facilities is in the same category, even recognising the discomfort that nicotine deprivation does cause to addicts on WDHB property.[42]

121 It is to be noted that the Court concluded that the dignity right was not engaged where the 'non-smoking policy [was] for the long term benefit of the patients'. Also of relevance was the fact that, as in the case presently under consideration, the policy was implemented with nicotine replacement and other therapies being made available to 'assuage the effects'.

122 In *R (on the application of N) v Secretary of State for Health*,[43] the English Court of Appeal considered an application by involuntary patients at a mental hospital challenging a smoking ban on the basis that it was incompatible with the rights of detained patients under art 8 of the European Convention on Human Rights and Fundamental Freedoms which provides that 'everyone has the right to respect for his private and family life, his home and his correspondence'.[44] Lord Clarke of Stone-Cum-Ebony MR and Moses LJ[45] recognised the special significance of imposing a smoking ban on involuntary patients, stating:

> 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

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42 Ibid [74].

43 [2009] HRLR 31.

44 In *Pretty v United Kingdom* (2002) 35 EHRR 1 [61], [65], the European Court of Human Rights found that the concept of 'private life' covered the physical and psychological integrity of a person and held 'The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance.'

45 Keene LJ dissenting.

> 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 art 8.[46]

123 The plurality held that the freedom was necessarily constricted within the confines of a secure hospital and that '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'.[47] Accordingly, the plurality concluded that art 8 did not protect the right to smoke because 'The prohibition does not, in such an institution, have a sufficiently adverse effect on a patient's physical or moral integrity'.[48]

124 In *CM v State Hospitals Board for Scotland*,[49] the petitioner, who was an involuntary patient in a mental hospital, not only contended that the smoking ban was beyond power (as referred to above), but also that the smoking ban engaged the right to protect his private life under art 8 of the European Convention on Human Rights and Fundamental Freedoms. In the Inner House of the Scottish Court of Session, Lord Justice-Clerk (Carloway)[50] noted that at first instance the Lord Ordinary had accepted that the petitioner had been deprived of one of his few pleasures and had found that the smoking ban was unlawful, inter alia, on the basis that it breached the petitioner's rights under art 8. Lord Justice-Clerk (Carloway) allowed the reclaiming motion on the basis that 'a comprehensive smoking ban does not, in an institution, have a sufficiently adverse effect on a person's physical or psychological integrity or his right to personal development as to merit protection'.[51] His Honour continued:

> Although addictive, smoking is essentially no different from the consumption of other products designed to sustain life or provide enjoyment or both. Many persons have cravings for different consumables from tea or coffee, alcohol in a variety of different forms, through to chocolate and other foodstuffs. However, in the context of an institution such as the state hospital, it is a question for management to decide what is to be made available to the patients. A decision to prohibit a particular product, or brand of product, does not engage Art 8 such that every decision to do so requires to be justified in terms of Art 8(2) if a

46 *R (on the application of N) v Secretary of State for Health* [2009] HRLR 31 [49].
47 Ibid [46].
48 Ibid [51].
49 [2014] CSIH 71.
50 With whom Lord Brodie agreed. Lady Paton dissented, finding that 'smoking is such an addictive activity that it is very much part of an individual's "personal autonomy"' therefore concluding that art 8 was engaged but the smoking ban was necessary in the interests of public safety, the prevention of crime and for the protection of health: [106].
51 Ibid [93].

> particular patient chooses to complain. No doubt, under the general duty of care owed to patients under domestic law, there requires to be an overall standard of provision which ensures that the health of the patients is not endangered but, in Convention terms, a decision to select or to prohibit, for example, a particular type or brand of consumable, different from the patient's favourite, does not engage Art 8 and the same principles apply to tobacco, or indeed alcoholic, products.[52]

Conclusion

125 Helpful as these international decisions may be, and mindful of the fact that s 32(2) of the Charter allows them to be considered in interpreting the Charter's provisions, I am fully aware of the care that needs to be taken with the use of such authorities, even if they are expressed in identical terms.[53]

126 I have also had regard to the fact that the human rights under the Charter should be construed in the broadest possible way. As Warren CJ said in *Re Application under the Major Crime (Investigative Powers) Act 2004*:

> As already observed, human rights should be construed in the broadest possible way. The purpose and intention of Parliament in enacting the Charter was to give effect to well-recognised and established rights in the criminal justice system. … The Charter supports the approach that rights should be construed in the broadest possible way before consideration is given to whether they should be limited in accordance with s 7(2) of the Charter. That section serves the purpose of mitigating any damage to society that may arise from upholding an individual's right.[54]

127 In my opinion, the determination of whether the Smoke Free Policy constitutes treatment of the plaintiff which is inhumane (or without humanity) or is without respect for his inherent dignity requires an evaluation of the relevant circumstances. This must be so because not every act which causes inconvenience, distress or even pain is inhumane; and not every act which limits the rights and freedoms of individuals can be said to be made without respect for the person's dignity. Further, what may not be inhumane or an affront to the dignity of a person, who is free to

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52 Ibid.

53 *Bare v IBAC* [2015] VSCA 197, 370 [617] nn 597 ('*Bare's* case'). See also *Momcilovic v The Queen* (2011) 245 CLR 1, 36 [19] (French CJ), 88–90 [151]–[159] (Gummow J, Hayne J agreeing at 123 [280]), 211 [546], 217 [565] (Crennan and Kiefel JJ).

54 (2009) 24 VR 415, 434 [80] (citations omitted).

return to his home, may be one or both of those things to an involuntary patient who suffers from mental illness and resides in an institution.

128 I consider that the relevant circumstances include the following. On one hand:

(a) Nicotine is a seriously addictive drug and, for a person who has been addicted for decades, withdrawal symptoms are likely to be distressing.

(b) The psychological effects of withdrawal may well be exacerbated by the following features:

(i) The withdrawal has been imposed upon the plaintiff.

(ii) The plaintiff suffers from a mental condition which may affect his ability to cope with the withdrawal symptoms.

(iii) The plaintiff is compulsorily detained and the pleasure he derives from smoking may be of considerably greater significance than to a person at liberty to seek alternative pleasures and distractions.

(iv) Remedial treatment such as the nicotine replacement therapy may cause side effects.

(c) The plaintiff may choose to continue to smoke on unescorted leave, which if he chooses to take more such leave, may result in him being not subject to care and supervision for more extended periods of time.

(d) The plaintiff says that his mental health is fragile and the physical and psychological symptoms resulting from withdrawal may cause a deterioration in his mental state.

129 On the other hand:

(a) The Smoke Free Policy is intended to be for the ultimate benefit of all the Hospital's patients, including the plaintiff, and staff – both present and future. Although it may be accepted that the burden of the implementation of the

Smoke Free Policy will fall more heavily on those of the present inpatients who smoke, if future patients and staff are to benefit from the Smoke Free Policy, a change (being the implementation of a ban) must occur at some point in time.

(b) The Smoke Free Policy is comprehensive and applies throughout the Hospital. In my opinion, the fact that the smoking ban applies to all patients, staff and visitors (and is intended to benefit those persons as referred to in part (a) above) militates against it being an affront to the dignity of the plaintiff or others affected by the decision.[55] In my opinion, a person's dignity is more likely to be affected if he or she has been singled out for treatment or a treatment is intended to be to his or her detriment.[56]

(c) The Smoke Free Policy has been introduced with a program which makes nicotine replacement therapy and other treatments available to the patients, including the plaintiff, to ameliorate the withdrawal symptoms. Introduced in this manner, it is difficult to suggest that the Smoke Free Policy constitutes treatment of the plaintiff without humanity and without respect for his inherent dignity.[57]

(d) I consider that the implementation of the Smoke Free Policy has been preceded by a number of years of careful consideration of the advantages and consequences of that policy, consultation with affected groups and with appropriate strategies to ameliorate negative effects.[58] Although this is plainly relevant to the satisfaction of the procedural requirement, I consider that the defendant's appreciation of the extended consideration, consultation and strategies for implementation makes it apparent that the decision was not taken arbitrarily or a product of discrimination against the plaintiff due to his condition.

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55 The comprehensive nature of the ban was considered relevant in *CM v State Hospitals Board for Scotland* [2014] CSIH 71 [93] (Lord Justice-Clerk (Carloway)).

56 *McNeill v Ministry of Solicitor-General and Correctional Services* (1998) 126 CCC (3d) 466 (Ont.Ct.J. (T.D)), 474.

57 *B v Waitemata District Health Board* [2013] NZHC 1702 [74].

58 See [10]–[73] above.

It may be said that the above considerations are relevant to the s 7 considerations and/or the procedural requirement rather than the question of the engagement of a human right. However, in my opinion a decision which transparently is:

(i) intended to benefit the affected person or the class of which the person is a member;

(ii) comprehensive; and

(iii) the product of careful consideration and consultation

is less likely to affect a person's dignity. On the other hand, a decision in respect of which these features are not apparent could be seen by the affected person as being arbitrary or discriminatory and is more likely to adversely impact on a person's dignity.

130 I acknowledge that the significance of a 'right to smoke' to an involuntary patient in a mental hospital may be of immensely more value than to persons in the general community. Accordingly, the decision to interfere with that right, taken after considering the relevant countervailing factors, may still 'be seen as cruel - cruel in the sense that it causes distress and even pain. But is it such cruelty as is forbidden by the Charter?'[59]

131 In my opinion, a comprehensive, properly considered smoking ban adopted after extensive consultation with patients does not impact on the dignity of the Hospital patients, including the plaintiff. Further, although the Smoke Free Policy is very likely to cause at least some distress to the plaintiff, it is a policy introduced for the purpose of protecting patients, staff and visitors from the known harmful effects of smoking; and I do not consider it to be inhumane to the Hospital patients, including the plaintiff. Accordingly, I do not consider that the Smoke Free Policy infringes the plaintiff's right to be treated with humanity and with respect for his inherent dignity so as to engage s 22 of the Charter.

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[59] *Regina Correctional Centre (Inmate Committee) v Saskatchewan* (1995) 133 Sask. R. 61, 63 [11] (Kyle J finding that a smoking ban in prisons did not offend the Canadian Charter of Rights and Freedoms).

Did the defendant fail to give proper consideration to the dignity right?

Plaintiff's submissions

132 The plaintiff submitted as follows:

(a) The evidence of Dr Magner reveals only the following occasions when the Charter was mentioned in the deliberations of the Breathe Easy Smoke Free Steering Committee:

(i) On 19 August 2014, Dr Magner sent an email to Dr Sullivan in which he requested 'some comments … to assist us in preparing some form of statement that needs to accompany the Smoke Free Policy'. The email states: 'Corrections have done their own assessment and in particular considered s 8 – the right to equality, s 10(3) the right to protection from cruel treatment, s 22 the right to humane treatment when deprived of liberty and s 13 the right to privacy'.

(ii) Dr Sullivan replied by an email dated 26 August 2014[60] in which he opined that 'the responsibilities of public agencies to protect others from second-hand smoke outweigh any putative "right to smoke"'.

(iii) Dr Magner asserts that, on 2 September 2014, 'the committee considered the human rights issues of going smoke-free with the benefit of Dr Sullivan's views; but, in fact, Dr Sullivan had not identified any single human right set out in the Charter. Dr Sullivan only said 'I think the smoking bans *engage* the rights set out in the Charter, but do not *enliven* them'.[61]

(b) On 13 November 2014, Dr Magner received a written advice from the corporate lawyer of the defendant, the legal risks paper, which included consideration of the Charter. According to the plaintiff, 'The advice itself mentions by name but does not further consider s 20 of the Charter and does not even mention s 22.

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60 The full text of which is at [43] above.

61 Emphasis in original.

The only sections given any consideration are ss 13 and 10 which are, quite rightly, found not to be relevant.'[62]

133 Accordingly, the plaintiff submitted that, on this evidence, the defendant did not meet the threshold required under the Charter of 'proper consideration' prior to making the decision to approve and/or adopt the Smoke Free Policy.

Defendant's submissions

134 The defendant submitted as follows:

(a) If the ultimate decision is compatible with human rights, in the absence of any clear error apparent from written reasons, the Court should be reluctant to make any finding that the decision-maker breached the procedural requirement.

(b) The Charter does not require that the consideration of human rights be recorded in writing and does not impose any independent obligation to give reasons. In this case, the plaintiff has made no request for reasons pursuant to s 8 of the *Administrative Law Act 1978*.

(c) Where written reasons are provided by an administrative decision-maker, they should not be over-zealously scrutinised for error, citing *Minister for Immigration and Ethnic Affairs v Wu Shan Liang*.[63]

(d) Where no formal written reasons have been requested or given, the documentation cannot be regarded as an exhaustive record of the consideration of the issues.

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62 As noted at [51] nn 4 above, the legal risks paper refers to s 20 of the Charter in respect of 'rights of patients to humane treatment when deprived of liberty' but I accept the defendant's submission that this is a typographical error and it was intended to be a reference to s 22. Accordingly, I accept that the legal risks paper identified s 22 as potentially relevant and only mentions s 20 in error and not in respect of the right of the plaintiff not to be deprived of his property other than in accordance with law. As outlined in [51] above, the legal risks paper identified ss 8, 9, 10, 13 and 22 of the Charter.

63 (1996) 185 CLR 259, 271–272 (Brennan CJ, Toohey, McHugh and Gummow JJ).

(e) The material before the Court demonstrates that the defendant gave careful consideration to the impact of the potential smoking ban on the plaintiff and other residents of the Hospital who are smokers.

(f) The defendant carefully considered and balanced the interests of the plaintiff and other residents who are smokers against the competing rights and interests including those of other residents, who are non-smokers, and employees.

(g) The failure to correctly identify or refer to a particular right does not amount to a breach of the procedural requirement because 'Decision-makers are not expected to approach the application of human rights like a judge "with textbooks on human rights at their elbows"'.[64]

The Attorney-General's submissions

135 The Attorney-General submitted that the defendant did give proper consideration for the following reasons.

136 The defendant understood that the decision would:

(a) prevent patients from having cigarettes anywhere inside the Hospital and from being able to smoke there;

(b) deprive patients of a lawful activity enjoyed by persons who were not detained; and

(c) psychologically and physiologically affect patients;

and thereby understood how patients, including the plaintiff, would be affected by the decision, and how the rights in sub-ss 22(1) and (3), in general terms, would be affected.

In support of this proposition, the Attorney-General relied upon the following:

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64 *Patrick's case* (2011) 39 VR 373, 442 [311] (Bell J) citing *R (SB) v Denbigh High School* [2007] 1 AC 100, 126[68]; see also *Castles' case* (2010) 28 VR 141, 176 [145] (Emerton J).

(a) The meeting between Dr Magner and Ms Collins and the Consumer Advisory Group on 4 July 2011.[65]

(b) The presentation by Dr Magner to the defendant's Council on 23 August 2012.[66]

(c) The presentation made by the consumer consultant representative to the Breathe Easy Smoke Free Steering Committee on 8 May 2013.[67]

(d) The July 2014 meeting of the Breathe Easy Smoke Free Steering Committee together with the email exchange between Dr Magner and Dr Sullivan in August 2014.[68]

(e) The report by Dr Magner to the defendant's Council in August 2014.[69]

(f) The meeting of the Breathe Easy Smoke Free Steering Committee on 2 September 2014.[70]

(g) The letter from a consumer consultant to the Chief Executive Officer dated 27 October 2014.[71]

(h) The legal risks paper prepared by the defendant's corporate lawyer provided to Dr Magner on 13 November 2014.[72]

(i) The meeting of the Breathe Easy Smoke Free Steering Committee on 10 February 2015.[73]

137 The defendant seriously turned its mind to the consequences that quitting would have for the patients, including the plaintiff, by the following:

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65 See [14] above.
66 See [20] above.
67 See [27] above.
68 See [42] and [43] above.
69 See [44] above.
70 See [45] above.
71 See [49] above.
72 See [51] above.
73 See [54] above.

(a) Creating extensive opportunities for patients, including the plaintiff, to express their concerns, both individually (including by online survey)[74] and through patient representatives.[75]

(b) Providing patients with substantial notice of the intention to ban smoking, including directions as to when and how the ban would be implemented.

(c) Putting in place extensive psychological and physiological support systems, including nicotine replacement therapy, QUIT counselling and group activities.

With respect to the support systems, the Attorney-General relied on the following evidence:

(i) The presentation by Dr Magner to the defendant's Council on 23 August 2012 including the materials and articles on policy implementation.[76]

(ii) The establishment of the Hospital planning group on 29 August 2012.[77]

(iii) The convening of the Breathe Easy Smoke Free Steering Committee in April 2013.[78]

(iv) The Breathe Easy Smoke Free Steering Committee received a presentation from the consumer consultant representative on 8 May 2013 and, at about that time, the Sharepoint Breathe Easy site was established.[79]

(v) The Breathe Easy Smoke Free Steering Committee on 17 July 2013 recorded responses to the staff survey and resolved to invite a QUIT

74 See [27], [31] and [32] above.
75 See [12]–[15], [18], [22]–[24], [26], [49] above.
76 See [20] above.
77 See [21] above.
78 See [25] above.
79 See [27] above.

staff member to join the committee to provide expert guidance and training.[80]

(vi) The participation of a QUIT staff member in the Breathe Easy Smoke Free Steering Committee from the meeting of 31 July 2013, including the decision to ensure that nicotine replacement was given for up to several months to fully cover the withdrawal phase.[81]

(vii) In December 2013, the terms of reference for the Breathe Easy Smoke Free Steering Committee were finalised which identified the committee's responsibilities including identifying what patient support should be put in place; and the families and carers of patients were informed of the decision to make the Hospital smoke free by 1 July 2015.[82]

(viii) On 7 May 2014, the Breathe Easy Smoke Free Steering Committee agreed that patients as well as staff could also become QUIT educated and the QUIT telephone support line would be available for all patients.[83]

(ix) On 24 October 2014, the CEO announced a staff support program, an updated intranet site and encouraged staff to support patients to go smoke free before 1 July 2015. A similar letter in the November edition of 'Family and Friends News' invited feedback and questions.[84]

138 The defendant identified the countervailing interests or obligations, which, in this case, was the health and wellbeing of patients and staff at the Hospital. The Attorney-General relied upon the following evidence:

(a) Dr Magner gave evidence as follows:

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80 See [29] above.
81 See [30] above.
82 See [35]–[36] above.
83 See [37] above.
84 See [48] above.

(i) The numerous sources relating to the long-established culture of smoking within mental health institutions and the serious effects on the physical health of smokers and exposed non-smokers.

(ii) Despite the reduction of smokers in the general community to 15.1%, smoking rates of above 66% were reported with people with psychotic disorders.

(iii) The major cause of the reduced life expectancy of people with schizophrenia is smoking related diseases; and smoking constitutes a strong independent risk factor for the development of mental illness.

(iv) There is no evidence that quitting smoking is harmful to patients with serious mental illness and there is evidence that cessation of smoking improves mental health.

(v) Partial bans on smoking are less effective than total bans in reducing exposure to passive smoking.

(vi) The defendant, as employer, had occupational health and safety obligations to its employees and it was not possible for any area of the Hospital to be completely off-limits to staff.

(vii) The National Tobacco Strategy 2012-2018 provides a national framework to reduce tobacco related harm in Australia and was endorsed by health ministers at the 9 November 2012 meeting of the Commonwealth Standing Council on Health. It identifies people with mental illness and prisoners as populations with a high prevalence of smoking and recognises that population wide approaches to smoking reduction need to reach out to those with mental illness.

(b) In May 2012, Dr Magner introduced the idea of the Smoke Free Policy and the first stage of the plan requiring all staff and contractors to smoke in designated areas.[85]

(c) Dr Magner followed this measure by providing a 'briefing attachment' to the defendant's Council in June 2012 setting out the purpose of the Smoke Free Policy being to improve the wellbeing of the Hospital's patients, clients and staff, and highlighting the 'considerable preparation required'.[86]

The defendant balanced these interests, by considering, for example, whether partial bans would achieve the same result and concluded that a partial ban would not be effective to achieve the countervailing objectives. In support of this proposition the Attorney-General relied upon the literature with respect to smoking in mental health institutions and, in particular, the literature provided to the defendant's Council on 23 August 2012.[87]

The Authorities

139 In *Castles' case*, Emerton J identified that consideration of human rights under the Charter was intended to become part of the usual decision-making processes at all levels of government. Her Honour said as follows:

> The requirement in s 38(1) to give proper consideration to human rights must be read in the context of the Charter as a whole, and its purposes. The Charter is intended to apply to the plethora of decisions made by public authorities of all kinds. The consideration of human rights is intended to become part of decision-making processes at all levels of government. It is therefore intended to become a 'common or garden' activity for persons working in the public sector, both senior and junior. In these circumstances, proper consideration of human rights should not be a sophisticated legal exercise. Proper consideration need not involve formally identifying the 'correct' rights or explaining their content by reference to legal principles or jurisprudence. Rather, proper consideration will involve understanding in general terms which of the rights of the person affected by the decision may be relevant and whether, and if so how, those rights will be interfered with by the decision that is made. As part of the exercise of justification, proper consideration will involve balancing competing private and public interests. There is no formula for such an exercise, and it should not be scrutinised over-zealously by the courts.

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85 See [15]–[16] above.
86 See [19] above.
87 See [20] above.

> While I accept that the requirement in s 38(1) to give proper consideration to a relevant human right requires a decision-maker to do more than merely invoke the Charter like a mantra, it will be sufficient in most circumstances that there is some evidence that shows the decision-maker seriously turned his or her mind to the possible impact of the decision on a person's human rights and the implications thereof for the affected person, and that the countervailing interests or obligations were identified.[88]

140 In *Bare's case*, Tate JA distilled the features of Emerton J's approach stating that to give proper consideration to a relevant human right, the decision-maker must:[89]

(a) understand in general terms which of the rights of the person affected by the decision may be relevant and whether, and if so how, those rights will be interfered with by the decision;

(b) seriously turn his or her mind to the possible impact of the decision on a person's human rights and the implications thereof for the affected person;

(c) identify the countervailing interests or obligations; and

(d) balance competing private and public interests as part of the exercise of justification.

141 I summarise their Honours' approach as follows: [90]

(a) The decision-maker must seriously turn his or her mind to the possible impact of the decision on the person's human rights and the implications thereof for the affected person; and identify the countervailing interest or obligations.

(b) The proper consideration requirement would not be satisfied by merely invoking the Charter 'like a mantra'. By this statement, Emerton J in my opinion was saying that it will not be sufficient for an authority to identify the Charter, or even the particular sections, and provide a pro forma explanation.

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88 *Castles' case* (2010) 28 VR 141, 184 [185]–[186].

89 *Bare's case* [2015] VSCA 197 [288].

90 *Castles' case* (2010) 28 VR 141, 184 [185]–[186] endorsed in *Bare's case* [2015] VSCA 197 [221] (Warren CJ), [279], [288]–[289] (Tate JA), [535]–[536], [538] (Santamaria JA); also approved in *Hoskin v Greater Bendigo City Council* [2015] VSCA 350 [35]–[36] (Warren CJ, Osborn and Santamaria JJA).

(c) On the other hand, it is not necessary that the decision-maker identify the 'correct' right which it may interfere with (ie the correct section under which the right is protected) or explain any content of any right by reference to legal principles or jurisprudence. It is necessary to identify in general terms the nature and extent of effect of the decision on the person's rights.

(d) After identifying the actual rights affected, the decision-maker will be required to balance the competing private and public interests.

(e) There can be no formula for the exercise and it should not be scrutinised over-zealously by the courts.

142 The requirement that review by the Court be of the substance of the decision-maker's consideration rather than the form was emphasised by Bell J in *Patrick's case*, where his Honour stated:

> The so-called 'procedural' limb of s 38(1) that 'proper consideration' be given to relevant human rights requires public authorities to do so in a practical and common-sense manner. … Decisions-makers are not expected to approach the application of human rights like a judge 'with textbooks on human rights at their elbows'.[91]

Conclusion

143 In my opinion, the evidence referred to in the Attorney-General's submissions[92] demonstrates that the defendant gave proper consideration to the right it proposed to limit by the implementation of the Smoke Free Policy. In my opinion, prior to the implementation of the Smoke Free Policy, the defendant comprehensively considered, over a period of approximately four years, the matters relevant to the decision to limit the plaintiff's (together with the other patients', employees' and visitors') choice to smoke on the Hospital premises, including any potential impact on the plaintiff's human rights under the Charter.

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91 (2011) 39 VR 373, 442 [311] citing Lord Hoffmann in *R (SB) v Denbigh High School* [2007] 1 AC 100, 126 [68].

92 Referred to in [136]–[138] above.

144 The fact that the Smoke Free Policy would prohibit the plaintiff's and others' right to smoke on the Hospital premises was self-evident. However, the procedures followed by the defendant prior to the implementation of the Smoke Free Policy ensured that, to the extent that it may not have already otherwise been obvious to Dr Magner and other executives of the defendant, the full impact of the decision on the plaintiff and other smokers was fully exposed. I particularly refer to the following:

(a) On 4 July 2011, Dr Magner and Ms Collins, a representative of the Victorian Mental Illness Advisory Council, attended a meeting of the Consumer Advisory Group which consisted of patient representatives. Ms Collins argued against Dr Magner's proposal that the Hospital go smoke free, and at that early meeting, the issues raised included the following:

(i) smoking is a human right and is not illegal;

(ii) smoking is a serious addiction;

(iii) it would be cruel to stop a sick patient from smoking; and

(iv) the Hospital is home for many patients who spend many years there.

(b) The letter dated 18 February 2015 specifically stated that the Breathe Easy Project is 'committed to a comprehensive consultation and implementation process that carefully considers the impact of the policy on all of those to be affected'.

(c) When the Breathe Easy Smoke Free Steering Committee was convened in April 2013, the membership was expanded to include a consumer consultant representative and others to recognise staff and patient needs. At the next meeting of the committee on 8 May 2013, the consumer consultant representative made a written presentation opposing the Smoke Free Policy which submitted that the Smoke Free Policy would be contrary to provisions in the New South Wales *Mental Health Act*, which required that any interference

with patients' rights, dignity and self-respect be kept to the minimum necessary in the circumstances.

(d) On 31 May 2013, the defendant commenced a process of consultation with consumers, carers and staff about the Smoke Free Policy which would include surveys, personal interviews (including with the plaintiff) and communication by letters, newsletters and internet. At about this time the 'Sharepoint Breathe Easy' Intranet site was established to allow information to be obtained from staff and patients about their attitudes to the Smoke Free Policy.

(e) Consideration was given to the detailed submission from Ms Dempsey, a consumer consultant, which detailed patients' concerns arising out of the proposed Smoke Free Policy by a letter dated 27 October 2014. The letter is set out in full at [49] above but the points made included that:

(i) smoking bans take away basic human rights of patients;

(ii) as involuntary patients, many of them do not have the option to go outside to smoke;

(iii) withdrawal cravings can last decades;

(iv) there is a risk of increased acuity and violence from the stress of forced withdrawal;

(v) nicotine replacement therapies can trigger trauma symptoms;

(vi) patients use cigarettes as a positive tool for managing mood;

(vii) the patients have been afforded no choice or options;

(viii) there are negative short term and long term effects of quitting smoking; and

(ix) smoking is one of the last luxuries patients have; and they do not have access to replacing systems used in the general community, such as

'access to sports clubs for fitness, a regular job to combat boredom and enhance citizenship and identity, and consuming alcohol as an accepted part of social activity and engagement with others'.

(f) By letter dated 18 February 2015, the Chief Executive Officer responded to Ms Dempsey's letter dated 27 October 2014 and the full text of the letter is set out at [50] above. In particular, he noted the following:

(i) the defendant appreciated the potential impact of quitting smoking on patients' mental and physical health in both the short and long term and said that the impacts had been taken into account in developing the Smoke Free Policy, in the form of the support measures; and

(ii) the process of implementing the Smoke Free Policy involved the balancing of a number of competing rights and interests.

(g) On 27 February 2015, the Smoke Free Policy was approved and the overview and purpose is set out at [56] above. It recognises that smoking is a serious addiction and that quitting smoking can be very challenging particularly for long term residents of a facility such as the Hospital. This fact was further recognised in the letter sent to each patient on 17 June 2015.

(h) The defendant's appreciation of the consequences of the implementation of the Smoke Free Policy is demonstrated by its recognition of the need for those affected by that policy to be provided with smoking cessation supports. This was recognised in the briefing attachment provided to the defendant's Council by Dr Magner as early as June 2012. It was reiterated throughout the preparation process and culminated in the Smoking Cessation Support Procedure published on 8 May 2015. The procedure is set out at [63] above and includes:

(i) nicotine replacement therapy for patients and staff;

(ii) access to the Quitline telephone support service;

(iii) group programs and quitting information seminars; and

(iv) other cessation support options including face-to-face support with doctors and counsellors.

145 I further note that identification of countervailing interests and obligations and the balancing of private and public interests was demonstrated throughout the process of obtaining approval for, and implementing, the Smoke Free Policy. In particular, the evidence establishes that the defendant had regard to the following:

(a) The rate of smoking in hospitals was substantially higher than the general community.

(b) The life expectancy of inpatients in mental institutions was substantially lower than the general community; and a major cause was the high incidence of smoking among patients.

(c) The evidence was that smoking is detrimental to mental health and that quitting smoking does not have a negative effect.

(d) The defendant had an obligation to improve the wellbeing of its patients.

(e) The defendant had occupational health and safety obligations to its employees.

(f) The Smoke Free Policy is consistent with the National Tobacco Strategy 2012-2018 endorsed by health ministers at the 9 November 2012 meeting of the Commonwealth Standing Council on Health.

146 I have also had regard to the fact that prior to the implementation of the Smoke Free Policy, Dr Magner, the Breathe Easy Smoke Free Steering Committee and the defendant's Council gave consideration to:

(a) extensive literature;

(b) overseas experience; and

(c) legal opinion

relating to the implementation of smoking bans in mental institutions.

147 Although, as noted above it is not critical, the defendant did identify specific provisions of the Charter that might be engaged, in particular:

(a) the legal risks paper prepared by the defendant's corporate lawyer provided to Dr Magner on 13 November 2014 specifically identified s 22 of the Charter;[93] and

(b) the Smoke Free Policy dated 27 February 2015 referenced the 'Human Rights Charter', s 22 – humane treatment when deprived of liberty, as did the Smoking Cessation Support Procedure published on 8 May 2015 and the Contraband Policy published on 2 June 2015.

The right against inhuman treatment

148 Section 10 of the Charter provides:

> A person must not be—
>
> (a) subjected to torture; or
>
> (b) treated or punished in a cruel, inhuman or degrading way; or
>
> (c) subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.

149 After completion of the hearing, the plaintiff applied for leave to further amend the originating motion to include an allegation that the Smoke Free Policy would breach the human right of the plaintiff to not be subjected to medical treatment without full, free and informed consent under s 10(c) of the Charter. The application for leave to further amend was opposed by the defendant and the Attorney-General but neither party pointed to any substantial prejudice that would be suffered by reason of the late amendment. Accordingly, I will give leave to the plaintiff to amend the originating motion as proposed.

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93 As noted at [51] nn 4 above, the legal risks paper refers to s 20 of the Charter in respect of 'rights of patients to humane treatment when deprived of liberty' but I accept the defendant's submission that this is a typographical error and it was intended to be a reference to s 22.

Plaintiff's submissions

150 In support of the contention, the plaintiff alleged that:

(a) the Smoke Free Policy fell within the definition of 'medical treatment' within the meaning of the Charter; and

(b) the defendant failed to give proper consideration to the relevant human right under s 10(c) in making the decision to implement the Smoke Free Policy.

151 The plaintiff noted that 'medical treatment' was not defined in the Charter but referred to the definition of that expression in s 7 of the *Mental Health Act 2014* and s 3 of the *Guardianship and Administration Act 1986*. It was submitted that for the purposes of s 10(c) of the Charter, 'medical treatment' should be defined as a remedy to an illness, disease, disorder or injury or other issue with a person's body (including any prophylactic care) normally carried out by, or under, the supervision of a registered medical practitioner. The plaintiff submitted that the 'unifying characteristic of each of these actions is that it is an intervention by a medical doctor aimed at improving or managing the health of that individual'. Accordingly, although exercise at a gymnasium would not generally be medical treatment, if it was prescribed by a doctor in response to a condition such as obesity, it would fall within the definition of medical treatment.

152 The plaintiff submitted that the Smoke Free Policy constituted medical treatment because:

(a) tobacco addiction or consumption is a problem to which the Smoke Free Policy is directed; and

(b) the Smoke Free Policy is directed at the treatment of tobacco addiction or consumption by withdrawal of access to tobacco products.

The fact that the measure may be prophylactic is not inconsistent with it being medical treatment.

153 As an involuntary patient 'the effect of the Smoke Free Policy on him will be to reduce (possibly permanently and indefinitely, if his living arrangements in the Hospital were to change) his access to tobacco products' without his consent.

154 Accordingly, it was submitted that the medical treatment consists of the reduction in consumption of cigarettes, which was imposed without consent and is designed to produce a therapeutic benefit.

155 Further, it was submitted that the Smoke Free Policy contemplates two other 'resulting, potential forms of medical treatment', being:

(a) nicotine replacement therapy, which recognises that the smoking ban was likely to induce withdrawal symptoms; and

(b) alterations in the dosages of clozapine because of the effect of cessation of smoking; or, more particularly, the effect of intermittent smoking.

156 The plaintiff submitted that the defendant failed to give proper consideration to the engagement of the human right under s 10(c) and relies upon his previous submissions about the lack of consideration of the Charter. Counsel for the plaintiff noted that the Smoke Free Policy is silent on s 10: the only reference to that section is under the Clozapine Guideline. Counsel further stated that the 'mere recitation'[94] of a human right is not sufficient to amount to proper consideration for the purpose of s 38(1).

Submissions of the defendant and Attorney-General

157 The defendant and the Attorney-General submitted that the right against inhuman treatment referred to in s 10(c) of the Charter was not engaged because:

(a) the Smoke Free Policy is a general policy that applies to all patients, staff and visitors on the Hospital premises;

[94] *Bare's case* [2015] VSCA 197 [285].

(b) the implementation of a smoking ban does not require specialist medical skills or knowledge; and

(c) the imposition of a smoking ban does not constitute treatment, much less medical treatment.

Authorities

158 The plaintiff correctly submitted that 'medical treatment' is not defined under the Charter. However, the Explanatory Memorandum for the Charter states as follows:

> Paragraph (c) establishes a right not to be subject to medical or scientific experimentation or treatment without full, free and informed consent. This sub-clause is also modelled on article 7 of the Covenant. This clause expands on article 7 of the Covenant as it also includes a prohibition on medical or scientific treatment without consent. In addition, it has been modified to provide that consent must be full, free and informed. This modification is intended to reflect the requirements for consent outlined in section 5(1) of the *Medical Treatment Act 1988*.[95]

159 Accordingly, I consider that medical treatment under s 10 of the Charter means medical treatment as defined by s 3 of the *Medical Treatment Act 1988*. Section 3 *Medical Treatment Act 1988* defines 'medical treatment' as the carrying out of —

(a) an operation; or

(b) the administration of a drug or other like substance; or

(c) any other medical procedure—

but does not include palliative care …

160 In *Re BWV; Ex parte Gardner*,[96] Morris J considered the meaning of 'medical treatment' as defined in s 3 of the *Medical Treatment Act 1988*. He concluded as follows:

> In my opinion, a medical procedure can generally be described as a procedure that is based upon the science of the diagnosis, treatment or prevention of disease or injury, or of the relief of pain, suffering and discomfort. … I think there is some force in Mr Burnside's submission that whether or not a procedure is a medical procedure depends upon whether the medical knowledge upon which it is based has become so widespread within the

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95 Explanatory Memorandum, Charter of Human Rights and Responsibilities Bill 2006 (Vic) 11.

96 (2003) 7 VR 487.

> community that it might now be regarded as common knowledge, not medical knowledge.[97]

To the extent that a smoking ban is based on medical science, in my opinion it is now such a matter of common knowledge that it could not be properly termed a medical procedure based upon medical knowledge.

161 The plaintiff submitted that the 'unifying characteristic of [a medical procedure] is an intervention by a medical doctor aimed at improving or managing the health of that individual'. Although in this case it would appear that the Smoke Free Policy was initiated by a medical practitioner, Dr Magner, I do not consider that his medical qualification was, on the evidence, a necessary feature of the decision to initiate the implementation of a smoke free policy. The Smoke Free Policy could easily have been initiated by a non-medically qualified executive and I would expect that in many other institutions this would have occurred. I do not consider that the qualifications of the person who initiates a smoking ban could determine whether s 10(c) is engaged.

Can a general policy fall within the definition of a medical procedure?

162 Generally, policies introduced for the purpose of improving the health of a group of persons would not fall within the definition of a 'medical procedure'. In this regard, a number of international decisions are illuminative.

163 In *CM v State Hospitals Board for Scotland*,[98] the petitioner contended that a smoking ban was inconsistent with s 1(4) of the *Mental Health (Care and Treatment) (Scotland) Act 2003*, which required that persons discharging functions under the Act must discharge the function 'in the manner that … involves the minimum restriction on the freedom of the patient that is necessary in the circumstances'. The petitioner contended that the smoking ban was in breach of the 'minimum restriction' obligation.[99] Lord Justice-Clerk (Carloway) drew a distinction between the care and treatment of a particular

97 Ibid 503–4 [75].
98 [2014] CSIH 71.
99 Ibid [47]–[52].

patient and the general management of the hospital.[100] As a result, his Lordship found that the smoking ban did not relate to the care and treatment of a patient and therefore was not subject to the 'minimum restriction' obligation and said:

> In the absence of evidence that smoking is a component part of the petitioner's medical care plan, the issue of whether he, or any other patient in the state hospital, should be permitted tobacco or allowed to smoke, in areas not covered by the general legislative smoking ban, is a matter for the respondents exercising their powers of management under the 1978 Act. It does not involve the discharge of a function under the 2003 Act. It is not a decision 'in relation to a patient' as envisaged in sec l of that Act. Accordingly, there was and is no need for the respondents to apply the principles contained in that section.[101]

164 In *New Health New Zealand Inc v South Taranaki District Council*,[102] Rodney Hansen J of the New Zealand High Court considered a challenge to a decision by a municipal council to add fluoride to water supplies on the basis that it breached s 11 of the *New Zealand Bill of Rights Act 1990*, which provides that 'everyone has the right to refuse to undergo medical treatment'.

165 His Honour considered that the process of fluoridation was undertaken for a therapeutic purpose[103] but dismissed the application on the basis that it did not constitute medical treatment, stating as follows:

> One would not naturally describe a person drinking fluoridated water or ingesting iodised salt as 'undergoing' treatment.
>
> …
>
> The language of s 11 in the context in which it appears strongly suggests that the right to refuse medical treatment is only engaged when the treatment takes place in the context of a therapeutic relationship in which medical services are provided to an individual.
>
> …
>
> The right to refuse medical treatment is to be confined to direct interference with the body or state of mind of an individual - what Mr Powell called ''the intimate sphere of human identity' - because within that sphere there are no competing interests that need to be moderated or resolved. Provided it does not have consequences for public health a person has the right to make even the poorest decisions in respect of their own health. But where the state, either

100 Ibid [65].
101 Ibid.
102 [2014] NZHC 395.
103 Ibid [79].

> directly or through local government, employs public health interventions, the right is not engaged. Were it otherwise, the individual's right to refuse would become the individual's right to decide outcomes for others. It would give any person a right of veto over public health measures which it is not only the right but often the responsibility of local authorities to deliver.
>
> …
>
> Were medical treatment for the purpose of s 11 to extend to public health initiatives, an individual right to refuse could cut across the obligation of the state to promote the health of its citizens.[104]

166 In *Regina Correctional Centre (Inmate Committee) v Saskatchewan,*[105] Kyle J considered an application in respect of whether a smoking ban at a prison offended various sections of the Canadian Charter of Rights and Freedoms including whether the ban constituted 'cruel and unusual treatment'. Kyle J dismissed the application and found that a smoking ban could not even be considered to be a 'treatment' within the meaning of the Charter. His Honour said:

> While tobacco is addictive it is also a health risk when smoked, not only to the user but to others and it is for these persons that the authorities have chosen to regulate its use. The resulting deprivation to the inmates is not therefore a punishment, *nor even a treatment*, but merely a necessary precaution to protect non-smoking employees and inmates (who may have a constitutional right not to smoke) from the effects of environmental or 'second hand' smoke. [106]

Conclusion

167 In my opinion, the Smoke Free Policy does not constitute medical treatment within the meaning of s 10(c) of the Charter for the following reasons:

(a) The plain meaning of the words 'medical treatment' would not include a smoking ban. One would not, in common parlance, speak of persons that are subjected to a smoking ban as being subjected to treatment, much less medical treatment. An employer who introduced a smoking ban in the workplace would not be said to be imposing medical treatment. I do not consider a smoking ban policy becomes 'medical treatment' because it is initiated by a medically qualified executive of a hospital.

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104 Ibid [82], [84], [86], [87]. Similar reasoning was applied in *Jehl-Doberer v Switzerland* (1983) E Comm HR No. 17667/91, 6.

105 (1995) 133 Sask. R. 61.

106 Ibid 63 [13] (emphasis added).

(b) Treatment, particularly medical treatment, would normally incorporate a connotation of positive intervention and the human right protected under s 10(c) would normally be confined to direct interference with the body or state of mind of the individual. Despite the general approach to broadly construe the human rights under the Charter,[107] I consider that the need for positive intervention is supported by reference to the other inhuman treatment referred to in s 10 being:

(i) torture;

(ii) cruel, inhuman or degrading treatment or punishment; and

(iii) medical or scientific experimentation without full, free and informed consent.

(c) A policy applied generally to a community for the purpose of improving public health would normally not have the necessary individual focus consistent with medical treatment.

(d) On the plaintiff's suggested definition, an element of 'medical treatment' is that it is 'normally carried out by, or under, the supervision of a registered medical practitioner'. There is no evidence that the imposition of a smoking ban requires such supervision; and one would not infer that it would be necessary.

Other treatments

168 The plaintiff also contended that s 10(c) of the Charter was engaged because the effect of the Smoke Free Policy was intended to be a reduction in smoking which could result in:

(a) patients or staff undertaking nicotine replacement therapy; and/or

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107 *Re Application under the Major Crime (Investigative Powers) Act 2004* (2009) 24 VR 415, 434 [80] (Warren CJ).

(b) patients requiring altered medication of clozapine particularly if the patient continued intermittent smoking while on leave.

169 In my opinion, the fact that the Smoke Free Policy may result in medical treatment being prescribed does not mean that the Smoke Free Policy engages the human right under s 10(c) protected by the Charter for the following reasons:

(a) The fact that certain action may cause the need for medical treatment does not render that action itself to be 'medical treatment'. Pushing someone from a cliff is very likely to result in medical treatment but it is not itself medical treatment.

(b) There is no evidence that any person will be compelled to accept nicotine replacement therapy, alteration in their clozapine dosages or any other medical treatment.

170 Accordingly, in my opinion the Smoke Free Policy does not engage the human right in s 10(c) being the right not to be subjected to medical treatment without full, free and informed consent. Consequently, it is not necessary to determine whether proper consideration was given to that right under s 38(1) of the Charter.

The effect of s 10(c) informing s 22 of the Charter

171 As part of the plaintiff's principal submission (which did not require an amendment), the plaintiff submitted that subjecting him to medical treatment without his consent was inconsistent with the obligation to treat him with humanity and with respect for 'the inherent dignity of the human person'. The link between the right to dignity and the right not to be subjected to inhuman treatment is supported by the statement of Kirby J in *Rosenberg v Percival* where he stated:

> Fundamentally, the rule [requiring informed consent to medical procedures] is a recognition of individual autonomy that is to be viewed in the wider context of an emerging appreciation of basic human rights and human dignity.[108]

[108] (2001) 205 CLR 434, 480 [145] (1) (citation omitted).

172 While it might be accepted that the human rights under 10(c) are also protected by s 22(1) of the Charter, I reject the contention that the Smoke Free Policy engaged the dignity right, or was more likely to engage the dignity right, because of the interaction with s 10(c) of the Charter because, for the reasons set out above, I do not consider that the Smoke Free Policy was medical treatment within the meaning of s 10(c) of the Charter.

Treatment of a person detained without charge

173 Section 22(3) provides as follows:

> An accused person who is detained or a person detained without charge must be treated in a way that is appropriate for a person who has not been convicted.

174 The plaintiff submitted as follows:

(a) The plaintiff is detained and he has never been convicted of any offence. As noted above, he was found not guilty of the murder of his mother by reason of insanity.

(b) Accordingly, he is entitled to be treated 'appropriately for a person who has not been convicted'.

(c) One of the express purposes of the Smoke Free Policy was to make the treatment of residents at the Hospital 'consistent with' prisoners. This demonstrates that the right to be 'treated appropriately' was liable to be breached and needed to be properly considered.

175 The defendant and the Attorney-General contended as follows:

(a) The plaintiff is not a person 'detained without charge'.

(b) The right under s 22(3) of the Charter has not been engaged because the plaintiff has been treated in a way that is appropriate for a person who has not been convicted.

Consideration

176 The rights in s 22 are modelled on art 10 of the International Covenant on Civil and Political Rights ('ICCPR') which provides as follows:

> 1. All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.
>
> 2.(a) Accused persons shall, save in exceptional circumstances, be segregated from convicted persons and shall be subject to separate treatment appropriate to their status as unconvicted persons;

177 The content of the rights in art 10 are informed by the United Nations Standard Minimum Rules for the Treatment of Prisoners which provide as follows:

> 82.(1) Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible.
>
> (2) Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management.
>
> (3) During their stay in a prison, such prisoners shall be placed under the special supervision of a medical officer.
>
> (4) The medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment.[109]

178 United Nations Human Rights Committee General Comment 21 explains that art 10, para 2(a), provides for the segregation, save in exceptional circumstances, of accused persons from convicted persons to emphasise their status as unconvicted persons who are entitled to be presumed innocent.[110]

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109 *Standard Minimum Rules for the Treatment of Prisoners*, adopted 30 August 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, UN Doc A/CONF/611, annex I, ESC res 663C, 24 UN ESCOR Supp (No 1) at 11, UN Doc E/3048 (1957), amended ESC res 2076, 62 UN ESCOR Supp (No 1) at 35, UN Doc E/5988 (1977). I note that this version was superseded by 'the Nelson Mandela Rules' which were unanimously adopted at the 88th plenary meeting of the UN General Assembly on 17 December 2015, subsequent to the trial of this proceeding. The relevant rules are now captured in rr 109-110 and are expressed slightly, though not significantly, differently. I also note that the Nelson Mandela Rules contain a new rule (r 25) directed to ensuring 'Every prison shall have in place a health-care service tasked with evaluating, *promoting, protecting and improving* the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation' (emphasis added).

110 Human Rights Committee, *CCPR General Comment No 21 : Article 10*, 44th sess, UN Doc HRI/GEN/1/Rev.1 at 33 (1994) (10 June 1992) [9].

179 The Explanatory Memorandum to the Charter confirms the fact that s 22(3) is based on art 10 of the ICCPR and that it broadens art 10 by requiring the humane treatment for accused persons and persons who have been detained without charge and includes the following statement:

> This clause is modelled on article 10 of the Covenant. Reference to article 10(3) of the Covenant has been specifically excluded in the Charter. Clause 22 broadens article 10 of the Covenant by requiring humane treatment for accused persons and persons who have been detained without charge. These rights may already be recognised under specific Victorian laws. For example, section 13ZB of the *Terrorism (Community Protection) Act 2003* provides that persons subject to preventative detention orders must be treated with humanity, respect for human dignity and must not be subjected to cruel, inhuman or degrading treatment.[111]

180 Although the plaintiff is detained and has not been convicted of an offence, I consider that the plaintiff is not a person to whom s 22(3) applies for the following reasons:

(a) On a plain reading of the section, it applies to persons who have simply been accused (and have not been tried) and persons who have been detained 'without charge'. The plaintiff has been charged and the charge was causally linked to his detention after he was found not guilty by reason of insanity.

(b) The Explanatory Memorandum indicates that the extension of the section to include persons who had been detained without charge, was intended to cover persons such as those who were detained under the *Terrorism (Community Protection) Act 2003*, which provides for preventative detention orders being made against persons who have not been charged.

(c) Reference to art 10(1) of the ICCPR and related material confirms that the principal concerns of the provision are that:

(i) accused persons who have not been tried should be dealt with differently and separately from convicted persons; and

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[111] Explanatory Memorandum, Charter of Human Rights and Responsibilities Bill 2006 (Vic) 17.

(ii) persons who suffer from a mental disability should not be detained in a prison for convicted criminals.

181 Further, in any event, I reject the plaintiff's submission that the Smoke Free Policy was adopted to make the treatment of residents at the Hospital 'consistent with' prisoners. The Smoke Free Policy was patently the result of concerns about the health of patients and staff. The Smoke Free Policy was initiated prior to plans to ban smoking in prisons.[112] In fact, the opponents of the Smoke Free Policy initially argued that prisoners, who were transferred to the Hospital due to mental illness, would be subjected to discrimination because they would lose the benefit of the choice to smoke due to having mental illness.[113] The imposition of the smoking ban in prisons removed this inconsistency and prompted the extension of the implementation date to align with the start of the smoking ban in prisons.[114]

182 I accept the submission of the defendant and the Attorney-General that the plaintiff has been treated in a way appropriate for a person who has not been convicted. In particular, the Smoke Free Policy has not been imposed for punitive purposes but for health and rehabilitative purposes.

Orders

183 For the reasons set out above, I propose to order as follows:

(1) The plaintiff have leave to amend the originating motion to allege that the defendant failed to give proper consideration to the plaintiff's human right not to be subjected to medical treatment without his full, free and informed consent under s 10(c) of the Charter.

(2) The originating motion be otherwise dismissed.

I will hear from the parties with respect to other orders including any further application with respect to s 20 of the Charter.

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112 See [17] above.
113 See [27(a)] above.
114 See [34] above.
