NOTE: HIGH COURT ORDER PROHIBITING PUBLICATION OF NAME OF APPELLANT REMAINS IN FORCE.

IN THE SUPREME COURT OF NEW ZEALAND

SC 60/2016
[2017] NZSC 88

BETWEEN	B (SC 60/2016) Appellant
AND	WAITEMATA DISTRICT HEALTH BOARD Respondent

Hearing:	16 November 2016 (Further submissions received 9 May 2017)
Court:	William Young, Glazebrook, Arnold, O'Regan and Ellen France JJ
Counsel:	R K Francois for Appellant J P Coates and P W Le Cren for Respondent P T Rishworth QC and P J Gunn for Attorney-General as Intervener
Judgment:	14 June 2017

JUDGMENT OF THE COURT

A The appeal is dismissed.

B There is no order as to costs.

REASONS
(Given by Ellen France J)

Table of Contents

Introduction

[1] The Waitemata District Health Board (the Board or the WDHB) has a smoke-free policy. No smoking is permitted inside the Board's premises and no staff, patients or visitors may smoke in external areas on any of the Board's premises. Anyone wanting to smoke must leave the grounds. Patients admitted to an Intensive Care Unit (ICU) in the Board's mental health units are confined to the unit over the course of their admission and so are unable to smoke.

[2] The appellant challenged the Board's smoke-free policy as it applies to patients in the Board's mental health facilities. He claimed the Board was obliged under s 6 of the Smoke-free Environments Act 1990 to establish dedicated smoking rooms in those institutions. Section 6 states that an employer "may" permit smoking by patients in a hospital care institution if there is a dedicated smoking room that meets the requirements of the Act. The appellant also claimed the Board's smoke-free policy breached his rights under the New Zealand Bill of Rights Act 1990 (the Bill of Rights). The claim was unsuccessful in the High Court[1] and in the Court of Appeal.[2]

---

1 *B v Waitemata District Health Board* [2013] NZHC 1702, [2013] NZAR 937 (Asher J) [*B v WDHB* (HC)].

2 *B v Waitemata District Health Board* [2016] NZCA 184, [2016] 3 NZLR 569 (Stevens, Cooper and Kós JJ) [*B v WDHB* (CA)]. Leave to appeal to this Court was granted in *B (SC 60/2016) v Waitemata District Health Board* [2016] NZSC 111.

[3] On appeal to this Court, there are two principal issues. The first issue is whether the Court of Appeal was right that s 6 of the Smoke-free Environments Act is permissive rather than imposing a mandatory obligation. The second issue is whether the Court was correct to conclude that the Board's policy was consistent with the Bill of Rights.

The background

[4] We first set out relevant facts about the appellant before describing the Board's mental health facilities and the development of its smoke-free policy.

The appellant

[5] The appellant is in his late 30's. He suffers from diabetes and a motor vehicle accident in 1998 resulted in traumatic brain injury. The appellant has been diagnosed as having a psychotic disorder, the primary diagnosis being one of paranoid schizophrenia. He is a cigarette smoker.

[6] The appellant was an inpatient at the Board's two acute adult inpatient units, Waiatarau and Taharoto[3] over a 12 week period beginning in June 2012.[4] He spent much of his time as an inpatient in an open ward. Whilst in the open ward he was able to leave the site to smoke between 9 am and 9 pm. The appellant was admitted to the ICU on three occasions for a total of about 11 days.[5] During that time he was confined. He spent another two days in a general hospital because of hyperglycaemia. The appellant was not able to smoke either in the ICU or whilst in the hospital.

---

3 The Taharoto unit has since been disestablished and a new 46 bed unit built on the site. The unit has been renamed He Puna Wāiora.

4 As the Court of Appeal noted, the appellant's first admission to Waiatarau was on a voluntary basis. He was subsequently transferred to Taharoto where he remained until 12 September 2012. He was subject to a community treatment order from 1 October 2012. His treatment order expired on 14 February 2013. See *B v WDHB* (CA), above n 2, at n 5.

5 The Board's records indicated admission for one hour on 29 June 2012, from 1–10 July 2012, and for 12 hours on 28–29 August 2012.

[7] The appellant, and two others, challenged the Board's policy in the High Court.[6] At that stage, the claim was based on two broad grounds. The first ground was a challenge to the lawfulness of the policy as inconsistent with legislation controlling the Board. The second ground related to consistency with the Bill of Rights. Both those grounds were pursued in the Court of Appeal although only the appellant appealed. The High Court and the Court of Appeal found the smoke-free policy was lawful and within the Board's powers. Both Courts also said the policy was consistent with the Bill of Rights.

The Board's mental health facilities

[8] At the time of trial, the Board owned or leased 178 facilities in total. Its mental health service included five inpatient sites and a number of community settings. The Taharoto unit is on the North Shore Hospital site and the Waiatarau unit is a part of the Waitakere Hospital site. At the time of the appellant's admission, the Taharoto ICU had nine beds and the Waiatarau ICU had eight beds.

[9] The WDHB also operates the Mason Clinic, an inpatient forensic psychiatry unit; the Kingsley Mortimer unit, an inpatient unit for older people with dementia and psychiatric conditions; and Pitman House, an inpatient unit as part of its alcohol and drug service.

Development of a smoke-free policy

[10] The policy under challenge in the proceedings was issued by the Board in November 2009.[7] It reflected policy development by the Board over a number of years. The New Zealand Health Strategy issued by the Minister of Health under s 8(1) of the New Zealand Public Health and Disability Act 2000 (the NZPHD Act) in 2000 provided the framework for the direction and the priority subsequently given by the Board to reducing smoking.[8] By that point in time, smoking on WDHB sites

---

6 The other plaintiffs were a former psychiatric nurse employed by the Board prior to her retirement and another psychiatric patient who had previously been under the Board's care.

7 Reference is made in the evidence to a later policy of March 2013. We were not informed of any material change from the 2009 policy.

8 *The New Zealand Health Strategy* (Ministry of Health, Wellington, December 2000). Reducing smoking was one of the priority health objectives in the Strategy which also recorded that tobacco smoking was the major cause of preventable death in New Zealand: at 14.

was in essence limited to a small number of designated smoking rooms and outdoors reflecting obligations under the Smoke-free Environments Act and the Health and Safety in Employment Act 1992.

[11] In 2002 the Board asked its executive team to consider the feasibility of the WDHB sites going smoke-free. By the end of that year, the Board made a decision in principle to move towards smoke-free sites.

[12] Over the next two years further work was done on the policy and on its implementation. A smoke-free policy was adopted in February 2005 under which all WDHB sites became smoke-free. At that point, the policy included an exception authorising smoking in designated areas in mental health units. One smoking room at North Shore Hospital remained until it was ultimately decommissioned in 2006.

[13] The smoke-free policy was revised in February 2006. In this version, there was an exception allowing for smoking in designated areas in mental health units. In 2007, there was a trial smoke-free policy in the Mason Clinic. The Rata unit in that clinic went smoke-free on a permanent basis in October 2008. Other mental health units under the WDHB's control became smoke-free over the following 12 months on a progressive basis. The last of the units to become smoke-free was Waiatarau. That unit became smoke-free in late 2009.

[14] The November 2009 policy provided that all of the Board's sites were smoke-free. Staff, patients and visitors were not permitted to smoke in external areas on a WDHB site and were required to leave the site if they wanted to smoke. The policy also dealt with the support to be provided to staff and patients who were smokers.

The statutory scheme

[15] To put the issues on appeal in context, we need to summarise the approach taken in the Smoke-free Environments Act and describe the provisions in other statutes relating to District Health Boards (DHBs).

The Smoke-free Environments Act

[16] The general purposes of the Smoke-free Environments Act include reducing the exposure of non-smokers to "any detrimental effect on their health caused by smoking by others".[9] The Act also aims to regulate the marketing and advertising of tobacco products and to monitor and regulate the presence of harmful constituents in tobacco products and tobacco smoke.[10]

[17] Reflecting these ends, the Smoke-free Environments Act is divided into three parts. Part 1 deals with smoke-free workplaces and public areas. Part 2 addresses the control of smoking products and the powers of enforcement officers are set out in pt 2A.

[18] The provisions in issue in this case are found in pt 1. Section 4 sets out the specific purposes for the part as follows:

> (a) to prevent the detrimental effect of other people's smoking on the health of people in workplaces, or in certain public enclosed areas, who do not smoke or do not wish to smoke there; and
>
> (b) to prevent young people who are being taught or cared for in registered schools or early childhood education and care centres from being influenced by seeing other people smoke there; and
>
> (c) to prevent the detrimental effect of other people's smoking on the health of young people who are being taught or cared for in registered schools or early childhood education and care centres.

[19] Under s 5(1) an employer "must take all reasonably practicable steps to ensure" there is no smoking "at any time in a workplace". A "workplace" is defined in s 2(1) in relation to an employer essentially as internal areas within the building occupied by the employer and "usually frequented" by employees as part of their employment.[11] There are some exceptions, for example, motels or hotel bedrooms or passenger sleeping compartments on a train.

---

9 Smoke-free Environments Act 1990, s 3A(1)(a).

10 Section 3A(1). This section also refers to the establishment of a Health Sponsorship Council. The Council was established by pt 3 of the Act as introduced, however all provisions relating to the Council were repealed by the New Zealand Public Health and Disability Amendment Act 2012.

11 "Internal areas" are defined in s 2(1) of the Act to mean an area within the premises or vehicle that, when closed up, is fully or substantially enclosed by, relevantly, a ceiling, roof or similar overhead surface, and by walls.

[20] There are two exceptions to the restriction on smoking in a workplace, namely, where smoking takes place in:[12]

> (a) a vehicle in which smoking is permitted under section 5A; or
>
> (b) a dedicated smoking room in which smoking is permitted under section 6.

[21] The conditions attaching to these two exceptions are set out in ss 5A and 6. Under s 5A an employer may permit smoking in the employer's vehicle where members of the public do not normally have access to the vehicle and the relevant employees agree. Section 6 deals with the conditions that must be satisfied before an employer "may permit" smoking in hospitals and other institutions. In essence, it is a prerequisite that the employer provide a suitably equipped dedicated smoking room and takes all reasonably practicable steps to minimise the possibility of smoke escaping to other parts of the workplace.

[22] There are also prohibitions or restrictions on smoking in other public areas, namely, schools and early childhood education and care centres; aircraft; passenger service vehicles; certain travel premises; licensed premises; restaurants; casinos; and some gaming machine venues.[13]

[23] The Director-General of Health is obliged to appoint enforcement officers[14] and there is provision for making complaints in relation to workplace smoking or contravention of any of the provisions of the Act.[15] Finally, pt 1 of the Smoke-free Environments Act provides for various offences. In particular, under s 17(1) an employer who fails to comply with s 5(1) (the prohibition on smoking in a workplace) commits an offence.[16]

---

12 Smoke-free Environments Act, s 5.
13 Sections 7A, 8, 9, 11, 12, 13, 13A and 13B respectively.
14 Section 14.
15 Sections 15 and 16.
16 The penalty is set out in s 17A(2).

Provisions relating to DHBs

[24] DHBs are established as Crown entities under the NZPHD Act.[17] The purpose of that Act is "to provide for the public funding and provision of personal health services, public health services, and disability support services, and to establish new publicly-owned health and disability organisations" so as to pursue the stated objectives, namely:[18]

> (a) to achieve for New Zealanders—
>
> (i) the improvement, promotion, and protection of their health:
>
> (ii) the promotion of the inclusion and participation in society and independence of people with disabilities:
>
> (iii) the best care or support for those in need of services: ...

[25] The Minister of Health is required by the Act to determine "a strategy for health services, called the New Zealand health strategy, to provide the framework for the Government's overall direction of the health sector in improving the health of people and communities".[19] The Minister responsible for disability issues must similarly determine a strategy for disability support services.[20]

[26] DHBs have a number of objectives, set out in s 22 of the NZPHD Act. In terms of this appeal, the following objectives are relevant:[21]

> (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:
>
> …
>
> (h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:

---

17 New Zealand Public Health and Disability Act 2000 [NZPHD Act], ss 5(3), 19(1) and 21.

18 Section 3(1). "[P]ersonal health services" and "public health services" are defined in s 6(1) of the NZPHD Act.

19 Section 8(1).

20 Section 8(2).

21 Section 22(1).

(i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:

…

(k) to be a good employer in accordance with section 118 of the Crown Entities Act 2004.

[27] For the purpose of pursuing these objectives, DHBs have a number of functions including "to promote the reduction of adverse social and environmental effects on the health of people and communities".[22] The DHBs' annual plans must "reflect the overall directions set out in, and not be inconsistent with, the New Zealand health strategy and the New Zealand disability strategy".[23]

[28] Finally, the Health and Safety in Employment Act imposed various requirements on DHBs as employers.[24] For example, under the Act employers had a duty to provide and maintain a safe working environment for their employees.[25]

An obligation to provide a dedicated smoking room?

[29] Whether there is an obligation on the Board to provide a dedicated smoking room to allow smoking in its mental health institutions turns on the interpretation of s 6 of the Smoke-free Environments Act. Section 6 provides as follows:

6 Dedicated smoking rooms in hospital care institutions, residential disability care institutions, and rest homes

(1) An employer may permit smoking by patients or residents of a workplace that is, or is part of, a hospital care institution, a residential disability care institution, or a rest home if—

(a) the smoking takes place only in 1 or more dedicated smoking rooms; and

(b) each dedicated smoking room is equipped with or connected to a mechanical ventilation system to which subsection (2) applies; and

---

22 Section 23(1)(h).

23 Section 38(2)(d).

24 The Health and Safety in Employment Act 1992 has now been replaced by the Health and Safety at Work Act 2015. Under the 2015 Act, the primary duty of care is that imposed by s 36 on a "person conducting a business or undertaking" (PCBU) (defined in s 17). A PCBU must ensure, "so far as is reasonably practicable, the health and safety of" its workers: s 36(1). See also s 36(3).

25 Health and Safety in Employment Act, s 6(a).

> (c) the employer has taken all reasonably practicable steps to minimise the escape of smoke from the dedicated smoking rooms into any part of the workplace that is not a dedicated smoking room; and
>
> (d) for each dedicated smoking room, there is available for patients or residents who wish to socialise in a smokefree atmosphere an adequate equivalent room.
>
> (2) This subsection applies to a mechanical ventilation system with which a dedicated smoking room in a workplace is equipped if, and only if,—
>
> (a) the system is so designed, installed, and operating that it takes air from the room to a place outside the workplace where any smoke the air may contain will not enter any part of the workplace, either—
>
> (i) directly; or
>
> (ii) through 1 or more other dedicated smoking rooms; and
>
> (b) no part of the workplace that is not a dedicated smoking room is equipped with or connected to the system.
>
> (3) Subsection (1)—
>
> (a) does not authorise an employer to permit a person who is not a patient or resident of the institution or home concerned to smoke in a dedicated smoking room; and
>
> (b) does not authorise a person who is not a patient or resident of the institution or home concerned to smoke in a dedicated smoking room.

[30] The argument that the word "may" in s 6(1) means that the Board "must" permit smoking does not appear to have been central to the appellant's case in either the High Court or the Court of Appeal, but both Courts concluded s 6 was permissive. Asher J considered the wording was clear, namely, that "employers *may* permit smoking, *if* the statutory criteria are fulfilled".[26] The Court of Appeal did not consider there was any basis for interpreting "may" to mean "must", noting that the context of the Act did not support that interpretation.[27]

---

[26] *B v WDHB* (HC), above n 1, at [39].

[27] *B v WDHB* (CA), above n 2, at [49]. The argument on this aspect in the Court of Appeal was made in support of a legitimate expectation patients could smoke on the Board's premises "in accordance with the right recognised by s 6": see at [46].

Discussion

[31] The word "may" is usually permissive or empowering.[28] However, in some situations read in context, "may" means "must".[29] Richardson P, delivering the judgment of the Court of Appeal in *Tyler v Attorney-General*,[30] endorsed the observation of Windeyer J in *Finance Facilities Pty Ltd v The Commissioner of Taxation of the Commonwealth of Australia* who stated that the general position is that "[w]hile Parliament uses the English language the word 'may' in a statute means may".[31] As Windeyer J also observed, in some circumstances, the permitted power must be exercised, and that will be dictated by "the particular context of words and … circumstances in which the power is to be exercised – so that in those events the word "may" means "must"".[32]

[32] We consider "may" in s 6 is permissive. That is its ordinary usage. In addition, we make the following points.

[33] First, to interpret "may" to mean "must" would be inconsistent with the statutory scheme. Section 5A, which deals with when an employer may permit smoking in a vehicle, states that:

---

28 *The Shorter Oxford English Dictionary* (6th ed, Oxford University Press, Oxford, 2007) vol 1 at 1731 where one of the definitions given for "may" is to "[h]ave the ability or power to … be allowed by authority, law, rule, morality, reason, etc". It is also noted that in some legal statutes, may means "shall, must"). See also: *Far North District Council v Local Government Commission* [1994] 3 NZLR 78 (HC) at 84, citing *Finance Facilities Pty Ltd v The Commissioner of Taxation of the Commonwealth of Australia* (1971) 127 CLR 106 at 134; *Tyler v Attorney-General* [2000] 1 NZLR 211 (CA) at [25]–[26]; *Julius v Lord Bishop of Oxford* (1880) 5 App Cas 214 (HL) at 222–223 and 225 per Lord Cairns LC (in this case the phrase was "it shall be lawful"); *Gibson v Manukau City* [1968] NZLR 400 (SC) at 406; *Re Wilson Home Trust* [2000] 2 NZLR 222 (HC) at [37]–[44]; Ross Carter "Statutory Interpretation in New Zealand's Court of Appeal: When 'may' means 'must', section headings affect interpretation, and latent Acts have effect" (2001) 22 Statute Law Review 20 at 24–26; and, generally, RI Carter *Burrows and Carter on Statute Law in New Zealand* (5th ed, LexisNexis, Wellington, 2015) at 316–319.

29 See, for example, *Julius v Lord Bishop of Oxford*, above n 28, at 222–223; *Finance Facilities*, above n 28, at 134–135; and *Morgan v BNP Paribas Equities (Australia) Ltd* [2006] NSWCA 197, (2006) 1 BFRA 639 at [66]. In *Acquired Holdings Ltd v Turvey* (2008) 8 NZBLC 102,107 (HC) Winkelmann J concluded that the word "may" in s 18 of the Consumer Guarantees Act 1993 (provision for various self-help remedies) was not entirely permissive: at [11]–[14].

30 *Tyler v Attorney-General*, above n 28, at [25].

31 *Finance Facilities*, above n 28, at 134.

32 At 134.

> An employer may permit smoking in a vehicle provided by the employer and normally used by employees or volunteers if—
>
> (a) the public does not normally have access to any part of it; and
>
> (b) all the employees and volunteers who use it regularly or from time to time have jointly or individually given the employer written notice—
>
> (i) asking the employer to permit smoking in it; or
>
> (ii) stating that they do not object to other employees and volunteers smoking in it; and
>
> (c) since last giving the employer notice to that effect, none of the employees and volunteers who use it regularly or from time to time has given the employer written notice that he or she—
>
> (i) no longer wishes the employer to permit smoking in it; or
>
> (ii) now objects to other employees and volunteers smoking in it.

It was accepted by counsel for the appellant during the hearing that the word "may" in s 5A means "may". Contrary to counsel's submission, there is nothing to suggest s 6 should be interpreted differently.

[34] Secondly, it is difficult on the face of s 6 to read the section as imposing an obligation. Rather, the plain meaning is that the section carves out an exception to the prohibition subject to the specified conditions being met.[33] Hence, the phraseology "may" followed by "if". Further, in s 6(3) the word "authorise" is used to describe the effect of subs (1). For example, s 6(3)(a) provides that subs (1) "does not authorise an employer to permit" non-residents to smoke in a dedicated smoking room. That language again suggests subs (1) is permissive rather than imposing an obligation.

[35] Thirdly, if the appellant was right, the effect would be to require a wide range of different types of institutions to provide dedicated smoking rooms. The institutions referred to in s 6 are defined in s 2 by reference to the definition of those

---

[33] A variant on this approach is where "may" is used in situations where more than one option is provided. The use of the word "may" in these situations can then denote a choice as to how the "must" obligation is performed.

institutions in s 58(4) of the Health and Disability Services (Safety) Act 2001.[34] As counsel for the respondent submits, the facilities covered by these definitions are very broad and include both public and privately funded providers of a range of services. Such a broad obligation seems an unlikely result given the legislative history, in particular, the strengthening in 2003 and in 2013, of the protections against exposure to second-hand smoking.

[36] The Smoke-free Environments Amendment Act 2003 made significant changes to ss 4–7 of the Act. Prior to the 2003 amendments, the purpose of pt 1 was, broadly, confined to preventing the effects of second-hand smoking.[35] Section 5(1) of the Act required employers to have a written policy on smoking. The policy was to "be based on the principle" that non-smokers or those not wanting to smoke at work, "shall, so far as is reasonably practicable, be protected from tobacco smoke in the workplace."[36] The policy had to include, relevantly, as minimum requirements a prohibition on smoking in specified areas such as lifts and in at least half of the total area of any cafeteria or lunchroom at the workplace, as well as in areas to which the public normally have access.[37]

[37] Section 5(6) made it clear the section did not prevent an employer from agreeing that smoking may be permitted in an enclosed area occupied by employees who all asked that smoking be permitted there or had no objection to the area being designated as a permitted smoking area.

[38] Further, prior to the 2003 amendments, s 6 set out special provisions for the smoking policies in hospitals, rest homes and prisons. Section 6(1) dealt with incapacitated patients or residents of a hospital or rest home. The section anticipated the policy would include a requirement for incapacitated patients or residents to be permitted to smoke other than in permitted smoking areas subject to the employer taking steps to protect others in the vicinity from the adverse effects of smoke.

---

[34] "Hospital care institution" means "premises used to provide hospital care" or the parts of premises used for that purpose; "residential disability care institution" means premises used to provide that care or the parts of premises used for that purpose; and "rest home" is defined similarly. "Hospital", "residential disability" and "rest home" care are, in turn, broadly defined in the Health and Disability Services (Safety) Act 2001: ss 4 and 6(2).

[35] Smoke-free Environments Act, s 4.

[36] Section 5(3).

[37] Section 5(4)(a).

[39] For prisons, s 6(2) required the prison superintendent to prepare a smoking policy for inmates. Again, it was anticipated some smoking would be permitted although the employer had to take various steps to protect the interests of non-smokers. The requirements for this policy included the following:

> …
>
> (b) The policy shall be based on the principle that inmates who do not smoke, or who do not wish to smoke, in the prison shall, except where it is impracticable, be protected from tobacco smoke in the prison:
>
> (c) Any inmate who requests that he or she be secured in a cell in which smoking will not be permitted while he or she is there shall, unless it is impracticable, be placed in such a cell:
>
> (d) Subject to paragraphs (a) and (b) of this subsection, the superintendent may designate any enclosed area used in common by inmates as an area in which smoking is permitted.

[40] As we have foreshadowed, following the 2003 Amendment, the scheme of the Smoke-free Environments Act provides that an employer "must" take all reasonably practicable steps "to ensure" no-one smokes in a workplace that is not either a vehicle in which smoking is permitted under s 5A or a dedicated smoking room in which smoking is permitted under s 6.[38]

[41] In addition, the 2003 Amendment introduced s 6A, dealing with smoking in prison cells.[39] In essence, s 6A required the superintendent of a prison to ensure there was a written policy on smoking in prison cells. Section 6A(2) set out the basis for the policy, as follows:

> (2) The policy—
>
> (a) must be based on the principles that—
>
> (i) as far as is reasonably practicable, an employee or inmate who does not smoke, or does not wish to smoke in the prison, must be protected from smoke arising from smoking in the prison's cells:

---

38 Section 5(1).

39 Section 6A was repealed, as from 5 March 2013, by the Corrections Amendment Act 2013, s 48(4).

> (ii) unless it is not reasonably practicable to do otherwise, an inmate who does not wish to smoke in his or her cell must not be required to share it with an inmate who does wish to smoke in it; and
>
> …

[42] We interpolate here that we consider Asher J was correct to place some weight on the difference between s 6A, which on its face anticipated there would be smoking in prisons, and s 6, which does not assume there will be smoking in hospitals, residential disability care institutions or in rest homes.[40]

[43] The 2003 Amendment as enacted reflected recommendations from the Health Committee which considered the Bill.[41] Both the Bill as introduced and a Supplementary Order Paper[42] proposed more minor changes to ss 5–7 of the Smoke-free Environments Act which still allowed smoking in some parts of workplaces (and as a consequence employers were still required to have a smoking policy). Nor were clauses concerning smoking in vehicles, dedicated smoking rooms in hospitals or the other institutions, or smoking in prison cells included in these earlier stages. The Committee's recommendations were to make all indoor workplaces completely smoke-free with some limited exceptions.[43] The exceptions generally reflected the concept that the excluded areas were a person's home, either on a temporary or a permanent basis.[44]

[44] In respect of smoking in prison cells, the Health Committee recommended:[45]

> … requiring all prisons to have a written policy regarding inmates smoking in prison cells. These policies must be based on the principle that inmates and employees should be protected from second-hand smoke. Prisoners may be allowed to smoke in their own cells, as long as non-smokers are not required to share a cell with them (as far as is reasonably practicable). We are advised that current practice is generally to allow smoking in cells and outdoor areas only.

---

40 *B v WDHB* (HC), above n 1, at [38] and [39]. The Court of Appeal agreed with Asher J that ss 6 and 6A were different, *B v WDHB* (CA), above n 2, at [50].

41 Smoke-free Environments (Enhanced Protection) Amendment Bill 2003 (310-2) (select committee report).

42 Supplementary Order Paper 2003 (148) Smoke-free Environments (Enhanced Protection) Amendment Bill 2003 (310-1).

43 Select committee report, above n 41, at 3.

44 At 4.

45 At 4–5.

[45] The Health Committee also discussed their recommendation for the insertion of a new provision dealing with patients in hospitals, and the other institutions covered by s 6:[46]

> We recommend allowing for dedicated smoking rooms for patients in hospitals, residential care homes and rest homes, to provide for patients who are so incapacitated that they are unable to go outside to smoke. No person other than a patient or resident will be able to smoke [in] such rooms, including employees and visitors.

[46] The parliamentary debates on the Bill also highlight that the rationale behind the inclusion of exceptions to the prohibition on smoking in the workplace was to allow people to smoke in areas which were considered the "private sphere", the home, or a temporary residence. In the second reading debate, Steve Chadwick MP, the Labour MP who sponsored the Bill, explained the rationale as follows:[47]

> The select committee recommends making all indoor workplaces completely smoke-free, with some limited exceptions around areas that are in the private sphere, such as hotel rooms. …

[47] The Associate Minister of Health, Hon Damien O'Connor, provided a similar explanation for those exceptions to the workplace prohibition:[48]

> The bill will provide 100 percent smoke-free protection in all indoor workplaces where two or more people work in a common airspace. … The Health Committee has considered that some exceptions are appropriate, such as workplaces that are a private citizen's home or a temporary residence. But separate indoor smoking areas for workers will go … .

[48] There was also brief discussion of s 6A and smoking in prison cells during the committee of the whole House. Ms Chadwick explained that the Department of Corrections wanted to maintain the ability for prisoners to smoke in cells for ease of management. The Health Committee had taken that advice on board and, generally speaking, a cell was treated as the prisoner's own room.[49]

---

46 At 5.
47 (25 June 2003) 609 NZPD 6610.
48 (30 July 2003) 610 NZPD 7457.
49 (13 August 2003) 610 NZPD 7946.

[49] Section 6A, dealing with smoking in prisons, was repealed in 2013.[50] The purpose for repealing s 6A seems relatively clear from the parliamentary debates during the committee of the whole House[51] and the third reading.[52] That is, as a means of enshrining the smoking ban in prisons introduced by the Department of Corrections as a policy in 2011. That policy had subsequently been subject to a legal challenge and found to be ultra vires by the High Court in *Taylor v Manager of Auckland Prison*.[53] During the third reading Hon Anne Tolley, Minister of Corrections, stated that:[54]

> The bill's priority to the Government has more recently been reinforced by amendments I introduced during its Committee stage removing any potential uncertainty about the lawfulness of the Government's smoke-free prisons policy. Since its introduction in July 2011 the smoke-free prisons policy has been a great success, making an important contribution to the health of prisoners and of corrections staff.

[50] In the parliamentary debates on the introduction of the Smoke-free Environments Bill to Parliament in May 1990, reference was made to the fact that the Bill was not "punitive" and did not "outlaw" smoking.[55] However, those observations only take us so far. They have to be considered in light of the subsequent changes to the legislation in 2003 and in 2013. Those changes support the observation of the Court of Appeal in *Progressive Meats Ltd v Ministry of Health* that the history since the passage of the Act suggests a move away from "the concept of mechanically ventilated rooms as providing, generally, a means of compliance with the Act" and a shift "from a permissive regime which envisaged the establishment of smoking rooms to a more restrictive regime".[56]

[51] For these reasons, we agree with the Courts below that there is no obligation on the Board to provide dedicated smoking rooms in its mental health institutions. Nor, given the view we reach on the Bill of Rights challenges, is any different interpretation necessary to ensure consistency with the Bill of Rights.[57]

---

50 Corrections Amendment Act, s 48(4).
51 (13 February 2013) 687 NZPD 7832 and following.
52 (26 February 2013) 687 NZPD 8186 and following.
53 *Taylor v Manager of Auckland Prison* [2012] NZHC 3591.
54 (26 February 2013) 687 NZPD 8187.
55 (17 May 1990) 507 NZPD 1634.
56 *Progressive Meats Ltd v Ministry of Health* [2008] NZCA 162, [2006] NZAR 633 at [42].
57 New Zealand Bill of Rights Act 1990, s 6.

[52] The absence of any obligation to provide a dedicated smoking room largely answers the argument the Board was acting outside of its powers in implementing the policy.[58] Nor, for the reasons we discuss in the context of the Bill of Rights challenge, is there any merit in the undeveloped contention that forcing patients to stop smoking in a mental health facility and attempting to end their nicotine addiction is not a mental health service as contemplated by the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The Bill of Rights challenges

[53] The high point of the case on the Bill of Rights is that the effects of withdrawal from smoking on a person in the appellant's position whilst in ICU are inhumane and deprive him of his dignity. We address this aspect, which requires consideration of s 23(5) of the Bill of Rights, first.

Right to be treated with humanity and with respect for dignity

[54] Section 23(5) of the Bill of Rights protects the rights of those "deprived of liberty" to "be treated with humanity and with respect for the inherent dignity of the person". The principles relevant to s 23(5) are those set out in *Taunoa v Attorney-General*.[59]

[55] That case dealt with the behaviour management regime (BMR) operated by the Department of Corrections over the period from 1998 to 2004 to deal with very disruptive prisoners. The BMR regime involved segregation from the main prison body and isolation of each prisoner for lengthy periods together with increased restrictions. The BMR regime was found to be in breach of s 23(5) but, except in relation to one inmate, not of s 9 of the Bill of Rights. Section 9 provides protection from torture, cruel, degrading or disproportionately severe treatment or punishment.

---

58 The appellant maintained this argument in written submissions but it was not developed in oral argument.

59 *Taunoa v Attorney-General* [2007] NZSC 70, [2008] 1 NZLR 429.

[56] There was not unanimity in *Taunoa* as to the relationship between s 23(5) and s 9.[60] But it is clear from *Taunoa* that the focus of s 23(5) is on conduct lacking humanity and the associated requirement on the relevant body to treat detained persons humanely. For example, Elias CJ said that "[a] requirement to treat people with humanity and respect for the inherent dignity of the person imposes a requirement of humane treatment".[61] Blanchard J referred to the protection:[62]

> … 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.

[57] Like the Court of Appeal in the present case, we do not see merit in the notion advanced by the appellant that "humanity" and the "inherent dignity of the person" are two separate limbs.[63] The section was not approached in that way in *Taunoa*. Rather, s 23(5) is read as a whole and encompasses the one, important, concept that "treating persons with humanity embraces respect for their dignity".[64] As the Court of Appeal also observed:[65]

> Section 23(5) closely follows the wording of art 10(1) of the International Covenant on Civil and Political Rights (ICCPR).[66] During the drafting of art 10(1) the words "and with respect for the inherent dignity of the human person" were added to meet a concern that the term "humanity" (or humanité) would not have the same meaning in various languages.

[58] Of the approach to art 10 Professor Manfred Nowak states that the article "primarily imposes … a positive obligation to ensure human dignity".[67] Professor Nowak continues:[68]

---

60 For example, Elias CJ did not see ss 9 and 23(5) as "simply different points of seriousness on a continuum" but rather, as identifying "distinct, though overlapping, rights": at [5]. Blanchard J saw s 23(5) as directed to conduct "of a lesser order" than s 9: at [170] and [176]–[177]. The latter view was, broadly speaking, the majority position. See at [285] and [297] per Tipping J, at [339]–[340] per McGrath J and at [383] per Henry J endorsing the approach of Tipping J to this topic.

61 At [79].

62 At [177].

63 *B v WDHB* (CA), above n 2, at [74]–[75].

64 At [74].

65 At [74] (footnotes omitted).

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

67 Manfred Nowak *UN Covenant on Civil and Political Rights*: *CCPR Commentary* (2nd ed, N P Engel, Kehl (Germany), 2005) at 250.

68 At 250 (footnotes omitted).

> Regardless of economic difficulties, the State must establish a minimum standard for humane conditions of detention … . In other words, it must provide detainees and prisoners with a minimum of services to satisfy their basic needs and human rights (food, clothing, medical care, sanitary facilities, education, work, recreation, communication, light, opportunity to move about, privacy, etc).

[59] The Court of Appeal rejected the notion that smoking is an activity connected to the dignity of the person.[69] In reaching this view, the Court saw merit in the approach taken by the Supreme Court of British Columbia in *R v Denison*.[70] That was a challenge in the context of a criminal trial to bylaws prohibiting smoking in the courthouse. It was contended that the bylaw was inconsistent with the right to "life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice" in s 7 of the Canadian Charter of Rights and Freedoms. In rejecting the challenge, Wilson J stated:[71]

> … I do not consider that the prohibition of smoking adversely affects the "security of the person" of Mr. Denison such as to be a breach of s 7. This is not a "basic choice going to the core of what it means to enjoy individual dignity and independence", as Mr Justice La Forest put it in the *Godbout* case; it is rather a matter of life-style choice.[72]

[60] We see the force in that approach in the present case, for the reason given by Wilson J and for the reasons we develop further in the context of considering a right to a home or private life.

[61] The appellant also submits that personal autonomy is a component of dignity or at least part of s 23(5) in its entirety. The appellant relies on the values discussed by Hammond J in *Attorney-General v Udompun*, such as the universality of the concept of human dignity.[73] Professor Nowak similarly notes the close relationship between the protection in art 7 of the International Covenant on Civil and Political Rights against cruel, inhuman or degrading treatment or punishment and art 9, the

---

69 *B v WDHB* (CA), above n 2, at [77]–[79].
70 *R v Denison* (1999) 70 WCB (2d) 758 (BCSC).
71 At [42].
72 The prohibition in the case was not a total ban in that Mr Denison was able to smoke before and after the Court hearing.
73 *Attorney-General v Udompun* [2005] 3 NZLR 204 (CA) at [196]–[203].

right to personal liberty and security of the person.[74] However, s 23(5) does not confer "an unbounded freedom" of those who are detained "to do as they please".[75]

[62] The aspect which in our view better repays consideration in the present case is whether the Board treated its patients in the ICU with humanity and respect for their dignity given their vulnerability and the impact of nicotine withdrawal. This requires an assessment of the policy in light of the need for appropriate management of nicotine withdrawal symptoms.

[63] The first point we make in terms of this assessment is that the Board's smoke-free policy proceeds on the basis that Board staff will be "proactive in offering support to staff and patients to quit smoking". Nicotine replacement therapy (NRT) is prescribed. Dr Patton, the clinical director for Mental Health and Addiction Services at the WDHB, explains that smoking status is assessed at admission. He also deposes that staff are trained in techniques for managing patient distress and arousal including those features caused by nicotine withdrawal.

[64] The appellant's evidence was that he did not find nicotine patches very effective in terms of reducing the craving to smoke. He said he also used lozenges but these were also only "marginally effective". The appellant described the irritability he experienced when unable to smoke. By contrast, he enjoyed the freedom of the open ward when he could smoke outside on the perimeter fence. The appellant makes the point that at the time of admission to ICU the patient is likely to be acutely unwell and therefore vulnerable.

[65] The appellant also relies on expert evidence about the effectiveness of NRT and evidence which indicates that rates of quitting smoking are not enhanced a great deal by cessation programmes where NRT is prescribed. For example, Dr Spriggs, a general physician working in the Departments of General Medicine and Older People's Health at the Auckland District Health Board provided affidavit evidence that tobacco smoking is a "serious" addiction and, according to the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric

---

74 Nowak, above n 67, at 172.
75 *B v WDHB* (CA), above n 2, at [77].

Association (DSM-IV) it is "a genuine mental disorder". (The diagnostic criteria associated with stopping or reducing nicotine intake listed in DSM-IV include dysphoric or depressed mood; insomnia; irritability, frustration, or anger; and anxiety.[76]) Dr Spriggs says that it is very hard for many people to quit smoking and that NRT is "often ineffective".

[66] Dr Burns, who is a medical practitioner and a fellow of the Royal Australian and New Zealand College of Psychiatrists, also provided evidence about the ineffectiveness of NRT in increasing quit rates of those not motivated to quit. He gave a brief overview of the Cochrane review, which he describes as the leading independent study on the effectiveness of NRT.[77]

[67] Dr Burns states that while the main findings of the review are that NRT increases the quit rates over control groups by about 60 per cent, the absolute quit rates are not high and depend on the setting. In particular, the most motivated group increase their quit rates from about 12 per cent to 19 per cent while the less motivated increase from about two per cent to three per cent.[78] Dr Burns concludes, therefore, that people who do not wish to quit smoking but are prescribed NRT are likely to have a less than three per cent chance of quitting.

[68] It is helpful to set this evidence in context. The Cochrane review notes as follows:[79]

> All of the commercially available forms of NRT (gum, transdermal patch, nasal spray, inhaler and sublingual tablets/lozenges) can help people who make a quit attempt to increase their chances of successfully stopping smoking. NRTs increase the rate of quitting by 50 to 70%, regardless of setting. The effectiveness of NRT appears to be largely independent of the intensity of additional support provided to the individual. Provision of more intense levels of support, although beneficial in facilitating the likelihood of quitting, is not essential to the success of NRT.

---

76 *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, American Psychiatric Association, Washington, 2000) at [290.0].

77 LF Stead and others *Nicotine replacement therapy for smoking cessation (Review)* (issue 11, The Cochrane Collaboration, 2012) [the Cochrane Review].

78 Dr Burns notes the review found that the lowest quit rate was in over the counter studies (2.1 per cent) and the highest rate was in smoking clinics (12.1 per cent). He also observes that the review found that the variation in control group quit rates was "attributable to differences in motivation".

79 Cochrane Review, above n 77, at 2.

[69] It is the case that these conclusions relate to smokers who are motivated to quit and who suffer from high levels of nicotine dependency. Nonetheless the conclusions provide some support for the Board's approach.[80] In addition, the evidence of Dr McRobbie, a medical practitioner and academic specialising in tobacco dependency and treatment, was that even "relatively short periods of abstinence" from smoking had health benefits particularly in terms of cardiovascular risk.[81]

[70] In any event, the more relevant question in this case is whether NRT is capable of reducing withdrawal symptoms in the short-term. This point is made by Dr McRobbie. He states that focusing only on evidence about quit rates ignores the fact that in the present context NRT is primarily being used to support temporary abstinence and to assist with symptom control. As to the symptoms and the ability of NRT to assuage the symptoms, Dr McRobbie points out that the time course of withdrawal symptoms is limited. He says that the most prevalent and severe symptoms will be experienced in the first two weeks. He accepts there is "no silver bullet" for smoking cessation but maintains that there are effective treatment options. His evidence includes the following:

> NRT has been shown to reduce tobacco withdrawal symptoms. Most studies show that NRT relieves craving, relieves depression, reduces anxiety, and improves poor concentration. Different types of NRT and modes of administration provide different types of relief. High dose patches completely suppressed a post-cessation increase in negative affect in smokers. High dose patch therapy may substantially alleviate background craving, but fast acting NRT may be needed to help with acute craving.
>
> (citations omitted)

---

80 Professor Lawn, in her affidavit, challenged the underlying suggestion mental health patients were not motivated to quit. She points to two studies as support for the proposition smokers with severe mental illness are just as interested in quitting as smokers in the general population or higher: Maxie Ashton and others "People with mental illness can tackle tobacco" (2010) 44 Aust NZ J Psychiatry 1021; and Ranita Siru, Gary Hulse and Robert Tait "Assessing motivation to quit smoking in people with mental illness: a review" (2009) 104 Addiction 719.

81 Professor Lawn similarly opined that "a period of abstinence has a direct health and financial benefit" for patients.

[71] Dr McRobbie went on to say that a nicotine nasal spray which was previously the fastest acting NRT product was found to be "particularly useful in helping highly dependent smokers to alleviate craving and stop".[82] He refers to a nicotine mouth spray which is now available that provides a more rapid relief of craving than nicotine lozenges and "is likely to be helpful to highly dependent smokers, for both temporary abstinence and smoking cessation". He also makes the point that while these withdrawal symptoms "can be unpleasant" they are "generally more mild than symptoms related to the withdrawal of other drugs of dependence".[83]

[72] Dr McRobbie's approach is consistent with other evidence before the Court. For example, a joint report by the Royal College of Physicians and the Royal College of Psychiatrists in England states that NRT is effective in people suffering from mental disorders "but is likely to be required in high doses, for longer durations and with more intensive behavioural support than in the general population of smokers".[84]

[73] It is relevant also in this context that the appellant was in the ICU for short periods. His length of admission was consistent with the average length of stay in the Taharoto and Waiatarau ICUs, respectively, 10.8 and 9.6 days.

[74] When the evidence is viewed overall, there is no basis for us to disturb the findings of the High Court, endorsed by the Court of Appeal, that the provision of NRT "while not a panacea", is "a humane and meaningful treatment" of nicotine withdrawal symptoms.[85]

---

82 Citations omitted.

83 In *Vogel v Attorney-General* [2013] NZCA 545, [2014] NZAR 67, in contrast, it was held there had been a breach of s 23(5) when Mr Vogel was confined to his cell as a penalty for drug-related disciplinary offences for longer than the available maximum penalty. Mr Vogel was a drug addict and had mental health issues. He had requested a period of confinement longer than the maximum to assist him in breaking his drug habit. Compare also *Attorney-General v Udompun*, above n 73, where it was held that there had been a breach of s 23(5) for failure to provide Ms Udompun, while detained pending removal from New Zealand, with sanitary products and a change of clothing.

84 *Smoking and Mental Health: A joint report by the Royal College of Physicians and the Royal College of Psychiatrists* (London, 2013) at 197.

85 *B v WDHB* (HC), above n 1, at [72]; aff'd *B v WDHB* (CA), above n 2, at [71].

[75] In this context, we also agree with the Court of Appeal that the statement by Brewer J in *Taylor v Attorney-General* that "[f]orcing prisoners into nicotine withdrawal is not humane"[86] does not advance matters in this case.[87] The context of that statement was quite different. The High Court was considering the vires of regulations establishing a ban on tobacco and smoking equipment in the prison. The reference to "humane" reflected a requirement in the Corrections Act 2004 that sentences be administered in a humane way.[88] But in any event, the courts in the present case have had the benefit of the evidence we have discussed about NRT.

[76] In assessing consistency with s 23(5) another relevant factor is that the Board introduced its policy after a comprehensive inquiry over the course of which it took advice and consulted with a range of interests.

[77] We can deal here with the appellant's challenge to the consultation process and in particular the criticism of the Board's failure to consult patients. Both the High Court and Court of Appeal concluded there was no duty to consult with psychiatric patients and staff prior to introducing the smoke-free policy.[89] Both Courts also considered that, if the Board was under such a duty, any requirement to consult was met.[90] Our review of the evidence shows that the finding the consultation met any duties on the Board was correct.[91] Two points can be made.

[78] First, having made its policy decision in December 2002 to move towards smoke-free sites, the Board undertook further policy development work over a number of years as part of which there was consultation with various groups. As we have noted, the Board's 2005 smoke-free policy included a limited exemption authorising smoking in mental health units while further work was undertaken in relation to mental health. Jocelyn Peach, who is part of the Board's Executive Leadership Team and co-managed the smoke-free project group, describes consultation over a period of time with a wide range of agencies including consumer

---

86 *Taylor*, above n 53, at [31].
87 *B v WDHB* (CA), above n 2, at [72].
88 Corrections Act 2004, s 5(1)(a).
89 *B v WDHB* (HC), above n 1, at [47]; and *B v WDHB* (CA), above n 2, at [56].
90 *B v WDHB* (HC), above n 1, at [48] and [50]; and *B v WDHB* (CA), above n 2, at [57].
91 We do not see the provisions of Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 relied on by the appellant as adding anything to the argument.

or patient representatives. She refers also, for example, to a public forum held in 2003 by West Auckland Shared Vision West, a group representing mental health consumers. The group set out its recommendations in respect of the Board's proposed non-smoking policy in mental health facilities from that forum in a letter dated 16 April 2003 to the Chairperson of the Board.

[79] Secondly, as part of the decision-making process, in 2007 the Board undertook a smoke-free pilot in the Mason Clinic. A clinical governance group set up to report to senior management about implementation of a smoke-free policy included a patient advocate. The Mason Clinic is a different type of institution from the two institutions in which the appellant was a patient because patients have much longer term stays in a forensic context. But there is nothing to suggest that the experience from that pilot was irrelevant to consideration of the application of the same policy to other mental health facilities.

[80] The particular complexities posed by smoking in mental health units are another aspect of an assessment of consistency with s 25(3). The statistics show an extremely high proportion of mental health patients are smokers relative to the proportion of smokers in the general population.[92] Further, there is material about specific problems posed by smoking in mental health institutions. To illustrate the point, Dr Patton's evidence is that there is an "entrenched" smoking culture in mental health institutions and that this culture has "many negative implications". For example, he refers to the use of "stand over tactics to procure cigarettes". Those behaviours require staff management. Further, Dr Patton describes smoking and access to tobacco having been used as "a tool of control by both patients and staff".

---

92 *Smoking and Mental Health*, above n 84, at 195 states that smoking is "around twice as common" among those with mental disorders "and more so" in those who have a "more severe disease". The findings from the 2003/2004 New Zealand Mental Health Survey Te Rau Hinengaro were that 32.3 per cent of people with mental illness (non-institutionalised) smoke compared to 20.7 per cent of people without mental illness: Shamina Bhikha, *The Use and Effectiveness of Smoking Cessation Programmes and/or Support by People with Mental Illness* (October 2008) at 3.

[81] Dr Patton also discusses various other policy considerations for the smoke-free policy. Some of these considerations are particular to the environment, for example, smoking creates a fire hazard and a method of self-harm. These risks increase the level of staff supervision needed to maintain safety. More generally, he says the policy "visibly promotes healthy lifestyles".

[82] The appellant relies on the move away from smoking bans in psychiatric hospitals in 2012 in Western Australia. This move appears to have been triggered by the death of a female patient. The patient was escorted off the premises to smoke and ran away. She was run over by a train. There are other illustrations of bans being reversed in Bradford Hospital in England in 2012 and in February 2013 in Hillmorton Hospital in Christchurch. However, the general trend in comparable jurisdictions appears to be towards bans in similar institutions.

[83] For example, Dr Patton's understanding is that similar bans have been imposed by most DHBs in New Zealand in inpatient mental health units. An article by Dr Anita Mackay provides information as to bans in other jurisdictions.[93] She states that in forensic institutions in Australia there are "some bans in place … . For example, in the state of [New South Wales] most have a smoke-free policy".[94] Of the United States, she says that psychiatric hospitals were excluded from a hospital ban that was imposed in 1992 but, "by 2011, 79% of facilities had implemented voluntary complete smoking bans".[95] Her information is that forensic psychiatric units in Canada began imposing bans from 2005 and that there were bans in these institutions in the United Kingdom from July 2008.[96]

[84] We add there is also some evidence that questions the efficacy of a partial as opposed to a full ban.[97]

---

93 Anita Mackay "The human rights implications of smoking bans in closed environments: What Australia may learn from the international experience" (2016) 46 IJLCJ 13 at 14, table 1.

94 At 14, table 1.

95 At 14, table 1.

96 At 14, table 1.

97 Dr McRobbie deposed that partial bans "give a mixed message" and that data from workplace smoking bans indicated a full ban had "a greater effect on decreasing smoking prevalence and consumption" in comparison to a partial ban. See also the discussion in Mackay, above n 93, at 19.

[85] Finally, we note that the Board also has obligations to others, in particular, to staff working with patients, to non-smoking patients and to visitors to the hospital. The Board obviously has to try to ensure staff and visitors and other non-smoking patients are protected from the adverse effects of second-hand smoke.[98]

[86] There is evidence before the Court that even in the outdoors there is a risk from second-hand smoke depending on various factors such as wind conditions and distance from the smoker.[99] Further, Dr McRobbie's evidence was that "even the best of ventilation systems working under perfect conditions" were not a complete protection from second-hand smoke.

[87] The general picture that emerges is that the introduction and implementation of smoking bans in these types of institutions is not without controversy. No doubt also, as the evidence suggests, the interrelationship between mental health and smoking is complex.[100] But both policy considerations and the Board's obligations to others in the mental health facilities provide a proper basis for the Board's policy and support the conclusion reached by both the High Court and the Court of Appeal. We accordingly conclude that, implemented in the way it has been by the Board

---

98 Mackay, above n 93, discusses some jurisprudence, albeit dealing with fairly extreme situations, in which non-smokers exposed to smoking in closed environments have been able to invoke human rights protection. She refers, for example, to *Florea v Romania* (37186/03) Section III, ECHR 14 September 2010 (applicant suffered from chronic hepatitis and arterial hypertension, was confined in overcrowded cell for about nine months and 90 per cent of his cellmates were smokers); and *Elefteriadis v Romania* (38427/05) Section III, ECHR 25 January 2011 (applicant suffered from chronic lung disease and was confined with smokers whilst in his cell and on other occasions). Compare *R (on the application of Solomon Smith) v Secretary of State for Justice G4S Care and Justice Services (UK) Ltd* [2014] EWCA Civ 380 at [48] (no breach of art 8 as a result of "relatively short exposure" whilst in prison to second-hand smoke). Whether it is appropriate to deal with the effect of other, conflicting, rights as a part of construing the right or as a matter of justified limitation under s 5 of the Bill of Rights may be a matter of debate, see, for example, Andrew Butler and Petra Butler *The New Zealand Bill of Rights: A Commentary* (2nd ed, LexisNexis, Wellington, 2015) at [6.6.19]–[6.6.36] but is not something we need to resolve here.

99 The appellant relies on a study by Neil E Klepeis, Wayne R Ott, and Paul Switzer "Real-Time Measurement of Outdoor Tobacco Smoke Particles" preprint for Klepeis et al (2007) 57 J Air Waste Manag Assoc 522. The authors conclude that outdoor tobacco smoke particle levels approached zero at distances more than about 2 m from a single cigarette. But the authors make it clear the levels are "highly dependent on wind conditions" and that it is possible for outdoor tobacco smoke particles to be at detectable levels "at downwind positions of [equal to or greater than] 4 m from a single active cigarette": at 13–14.

100 See the discussion of the evidence in the extract from the Divisional Court's judgment in *R (G) v Nottinghamshire Healthcare NHS Trust* [2008] EWHC 1096 (Admin), [2009] PTSR 218 in Appendix A to *R (N) v Secretary of State for Health* [2009] EWCA Civ 795, [2010] PTSR 674.

following a careful process and with the provision of NRT for those who need it, the policy does not breach s 23(5).

[88] We add that these factors also indicate the Court of Appeal was correct to conclude that the smoke-free policy is consistent with the Board's obligations in s 22(1)(i) of the NZPHD Act to uphold the ethical and quality standards expected of care providers.[101]

Cruel or disproportionately severe treatment

[89] Section 9 of the Bill of Rights provides as follows:

> Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment.

[90] In the High Court Asher J said the threshold for breach of s 9 was a "high" one and "quite plainly" was not met in the appellant's case.[102] The Court of Appeal similarly concluded the appellant had fallen "well short" of showing a breach of s 9 with respect to disproportionately severe treatment.[103]

[91] We agree with the conclusions in the Courts below. The policy cannot be shown to meet the high threshold for a breach of s 9. The Board implements its policy knowing that it will cause some pain and distress and that patients are likely to be particularly vulnerable at the time of admission to the ICU. However, as we have discussed, the response to that is to treat the patients in a humane way, in particular, by making NRT available.

[92] We do not see this case as raising concerns close to those arising out of the BMR regime considered in *Taunoa*.[104] To take Mr Taunoa's case as an illustration, this Court by a majority of three to two found there was no breach of s 9 in relation to his time on the BMR regime. It is helpful to briefly note the features of the BMR

---

101 *B v WDHB* (CA), above n 2, at [31]–[32]. *Smoking and Mental Health*, above n 84, deals with ethical aspects of smoking bans in mental health institutions and says the "moral imperative of healthcare institutions to promote the mental and physical health of their patients (and to protect and support the mental and physical health of their staff) justifies a shift in culture "within mental health institutions away from one that supports smoking": at 200.

102 *B v WDHB* (HC), above n 1, at [71].

103 *B v WDHB* (CA), above n 2, at [67].

104 *Taunoa*, above n 59.

programme, which were "the conditions of segregated cell confinement, the practice of strip searching prisoners and failures to check their mental health condition either at the outset or during the time they were the subject to the [BMR] regime".[105] As McGrath J described:

> [347] The appellants were subject to segregated cell confinement, initially for 23 hours and later for 22 hours of each day. Associated with that confinement were some practical limitations on their ability to converse with others, although conversation was permitted with those in other cells. Importantly, indoor and outdoor exercise during unlock periods was not available for significant periods. … Prisoners on the BMR regime were entitled to exercise daily. However, they were entitled to outdoor exercise only twice a week and for long periods of time this entitlement was not made available. For example, Mr Taunoa received only 21 outdoor exercise "yards" on his second period of the BMR when, even on that regime, he should have received nearly 200. …
>
> [348] The regime also had an impact on cell cleaning and on the state of cell hygiene … . Where an inmate is deprived of the means of maintaining personal hygiene, or the hygiene of his place of incarceration, the conditions become incompatible with respect for human dignity. … These factors add force to a further relevant point, … concerning the punitive nature of the restrictions of segregated confinement under the regime from the perspective of those who had to suffer it. …
>
> [349] … Strip-searching of those on the BMR regime included routine searches. Often they took place in circumstances where there was no practical possibility of prisoners carrying secreted items on their return to the BMR area.

[93] Tipping J, in concluding there was no breach of s 9, saw the absence of deliberate causing of harm as relevant along with the absence of "some additional element either of degree or of kind" to take the conduct over the threshold.[106] McGrath J concluded that the overall gravity of Mr Taunoa's mistreatment did not reach the requisite "level of harshness".[107]

[94] In the context of a smoking ban in a prison, the Ontario Court (General Division) in *McNeill v Ontario (Ministry of Solicitor General and Correctional Services)* also rejected a claim the ban comprised "cruel and unusual treatment" or punishment inconsistent with s 12 of the Canadian Charter.[108] O'Connor J noted that

---

105 At [346] per McGrath J.
106 At [283] and [285].
107 At [362].
108 *McNeill v Ontario (Ministry of Solicitor General and Correctional Services)* (1998) 126 CCC (3d) 466 (Ont Ct (Gen Div)).

while nicotine withdrawal was "an unpleasant and difficult experience", it was both "temporary and limited".[109] The Judge also made the point that the "former smoker does not require medical attention" and the policy was implemented in a manner sensitive to Mr McNeill and other smoker inmates.[110] The Judge doubted that the ban came within the meaning of "treatment" in s 12 but if it did, it fell "far short of being cruel and unusual" especially given its objective was one of public health so it was "both not intended to be [and] nor is its effect cruel and unusual".[111]

[95] We are satisfied there was no breach of s 9 of the Bill of Rights.

Discrimination on the basis of disability

[96] Under s 19(1) of the Bill of Rights "[e]veryone has the right to freedom from discrimination on the grounds of discrimination in the Human Rights Act 1993". The prohibited grounds of discrimination in s 21(1) of the Human Rights Act include disability.[112] The definition of "disability" in s 21(1)(h) includes "(iii) psychiatric illness".[113]

[97] Asher J found there was no discrimination on the grounds of psychiatric illness.[114] That was so as the basis of the prohibition on smoking was not that the appellant was a psychiatric patient but because he, like any other visitor, was on hospital grounds and so was required to observe the rules applicable whilst in the grounds.[115] The Judge also concluded there was no discrimination on the basis of disability.[116] Asher J found addiction to nicotine was not a disability as defined in the Human Rights Act.[117]

---

109 At 472.
110 At 472.
111 At 472–473.
112 Human Rights Act 1993, s 21(1)(h).
113 Disability also includes physical disability or impairment or illness, intellectual or psychological disability or impairment, any other loss or abnormality of psychological, physiological, or anatomical structure or function, reliance on a guide dog, wheelchair or other remedial means, and the presence in the body of organisms capable of causing illness: Human Rights Act, s 21(1)(h).
114 *B v WDHB* (HC), above n 1, at [56]–[63].
115 At [60].
116 At [64]–[69].
117 At [65].

[98] In upholding Asher J's conclusion on this issue the Court of Appeal said the proper comparison was not between smokers with psychiatric illness in the ICU and smokers with psychiatric illness in the open ward, some of whom are free to reach the hospital boundary and smoke outside it.[118] That was because use of that comparator would "import the characteristic of smoking into the comparison",[119] in reality, a claim to a right to smoke.[120] There was no obligation on the Board to make smoking available to those who cannot exercise that privilege otherwise.

[99] The Court's reasoning is summarised in this passage:

> [95] Mr B, and other patients like him, were placed in the ICU because they had been assessed as being a safety risk, not because of a prohibited ground. Once such patients were in the ICU they were treated in exactly the same way as all others in an ICU. The basis of the prohibition on smoking was not because Mr B and others were psychiatric patients in the hospital generally or in the ICU. It is as Asher J said: "simply because they, like any visitors to the WDHB's premises, are on the hospital's grounds and must observe its rules insofar as those rules do not impinge on protected rights".
>
> [96] We are satisfied the smoking ban implemented by the Smoke-free Policy involved a neutral rule with no particularised effect on psychiatric patients. The impact on that group flowed from the independent operation of a further (and legitimate) policy premised on the safety of the detained person and others whom they might otherwise harm. It was *that* rule that resulted in their detention in ICU. The patients were then treated in exactly the same way as all others required, for any reason (for example, as staff or having non-psychiatric disability), to be in ICU. There was no differential treatment by reason of having a psychiatric illness, even one that manifested itself in there being potential harm to themselves or others. The detention arose out of the appropriate operation of the treatment regime for compulsorily detained patients. Accordingly there was no different treatment on a prohibited ground.
>
> (footnotes omitted)

[100] For essentially the same reasons we agree.

[101] There was no argument before us that it was not possible to advance a claim based on intra-ground discrimination. That is, discrimination as between subsets of

---

118 *B v WDHB* (CA), above n 2, at [97].
119 At [97].
120 At [98].

classes protected from discrimination.[121] But, here, the challenged impact is simply another consequence of detention. There is no differential treatment as between groups in comparable situations on the basis of a prohibited ground of discrimination.[122] As counsel for the WDHB submits, there are others in the Board's mental health facilities who cannot leave to smoke, for example, because they are in general hospital and are too sick or the ward may be locked or permission to leave the grounds may not be granted. The appellant is detained because of a disability, but he is not discriminated against on that basis. Rather, a policy which is applicable to all in the hospital is applied to him.

[102] In rejecting a claim against the ban on smoking in prison based on discrimination in *McNeill*, O'Connor J adopted similar reasoning.[123] The Judge was concerned that the disability ground for protection in the Canadian Charter should not be "trivialized or minimized".[124] Part of the Judge's rationale for not accepting this part of the claim was that the ban was not one "based on the stereotype of Mr. McNeill as a smoker".[125] Rather, it was based on "the actual circumstances under which he finds himself".[126]

[103] The same result was also reached by the Supreme Court of the United Kingdom in the recent case of *McCann v The State Hospitals Board for Scotland*.[127] In that case, the Court dealt with the legality of a smoking ban at the State Hospital at Carstairs, Scotland. The ban in issue was a comprehensive one which prohibited patients and visitors from smoking tobacco products in the hospital, including on its grounds, or on home visits. The ban was also accompanied by a prohibition on possession of tobacco products and procedures for the search and seizure of such products. While the Court in *McCann* ultimately held that the ban at

---

121 Butler and Butler, above n 98, at [17.16.1] give as an illustration the situation where persons with one form of disability, say blind persons, are eligible for various entitlements but persons with another disability, for instance deaf persons, who would also benefit from those entitlements are not eligible for them.

122 *Ministry of Health v Atkinson* [2012] NZCA 184, [2012] 3 NZLR 456.

123 *McNeill*, above n 108.

124 At 473.

125 At 474.

126 At 474.

127 *McCann v The State Hospitals Board for Scotland* [2017] UKSC 31, [2017] 1 WLR 1455 [*McCann* (UKSC)]. We obtained further submissions from the parties on *McCann* following its release.

issue in that case was illegal for reasons discussed further in a later part of this judgment,[128] the Court found that the ban did not result in any unjustified discrimination when detained patients were compared with members of the public who were free at large.[129]

[104] Lord Hodge, delivering the judgment on behalf of the Court, explained:[130]

> The circumstances of such members of the public are radically different as (i) they have opportunities to smoke in places which do not expose others to second-hand smoke, and (ii) the public authorities do not have any legal duty of care to create a safe therapeutic environment for them or to protect their own staff from injury to health when they are in the public sphere and not acting in the course of their employment. The documents … reveal the problems of allowing smoking out of doors in a secure hospital. Such problems do not occur among the general public. The differences between the anti-smoking policies applied to them and the comprehensive ban in the State Hospital can readily be justified.

[105] We do not consider the policy is a breach of the right to freedom from discrimination on the grounds of disability.

Right to a home or private life?

[106] Section 28 of the Bill of Rights reads as follows:

> An existing right or freedom shall not be held to be abrogated or restricted by reason only that the right or freedom is not included in this Bill of Rights or is included only in part.

[107] In order to succeed in this part of his case, the appellant has to show that a right to home or private life is protected by s 28 and that the right to smoke comes within the right to home or private life.

[108] It is important to note first that s 28 makes it clear that other rights and freedoms not included in the Bill of Rights are not affected by their non-inclusion. In other words, the section is akin to a savings provision ensuring that existing rights

---

128 Below at [115].
129 *McCann* (UKSC), above n 127, at [65].
130 At [65].

and freedoms not included in the Bill of Rights or included only in part are not abrogated.[131]

[109] In relation to the equivalent provision in the Canadian Charter, s 26, Professor Hogg states:[132]

> Section 26 is a cautionary provision, included to make clear that the Charter is not to be construed as taking away any existing undeclared rights or freedoms. Rights or freedoms protected by the common law or by statute will continue to exist notwithstanding the Charter. Section 26 does not incorporate these undeclared rights and freedoms into the Charter, or "constitutionalize" them in any other way. They continue to exist independently of the Charter, and receive no extra protection from the Charter. They differ from the rights or freedoms guaranteed in the Charter in that, as creatures of common law or statute, the undeclared rights can be altered or abolished by the action of the competent legislative body. As well, the remedy under s. 24 is not available for their enforcement.[133]

[110] Applying this line of reasoning, the Court of Appeal said s 28 did not remove the requirement that the appellant establish the existence of the right relied on, here, a right to home or private life which encompassed the right to choose whether or not to smoke.[134]

[111] In supporting the Court of Appeal judgment, counsel for the Attorney-General accepted that those in New Zealand have a general residual liberty, that is, to do that which is not prohibited by law. That includes a liberty to smoke cigarettes. However, the submission is that the fact there is a liberty to smoke does not convert that into an existing right. In other words, there is no right to residual liberty whether in the Bill of Rights or in the common law. Counsel for the Attorney-General cited Baroness Hale in *R (Countryside Alliance) v Attorney*

---

131 Geoffrey Palmer "A Bill of Rights for New Zealand: A White Paper" [1984–1985] I AJHR A6 at [10.179]. It seems implicit in the limited discussion of s 28 that it must be shown there is an existing right. See, for example, *M v Minister of Immigration* [2012] NZCA 489, [2013] 2 NZLR 1 at [10]–[21]; and see also *Brooker v Police* [2007] NZSC 30, [2007] 3 NZLR 91 at [214], [228] and [229] per Thomas J (dissenting).

132 PW Hogg *Constitutional Law of Canada* (looseleaf ed, Thomson Reuters) at [36.12] (footnotes omitted).

133 Manfred Nowak makes a similar point in relation to the equivalent provision in the International Covenant on Civil and Political Rights, namely, art 5(2). Professor Nowak describes this as a savings clause which "gives expression to the principle that the rights of the Covenant merely represent a *minimum standard* and that the combined effect of various human rights conventions, domestic norms and customary international law may not be interpreted to the detriment of the individual": Nowak, above n 67, at 112.

134 *B v WDHB* (CA), above n 2, at [102].

General in support of this proposition.[135] That case dealt with whether fox hunting came within the guarantee of private life in art 8 of the European Convention on Human Rights. Baroness Hale observed that, until the Human Rights Act 1998 (UK) came into force, the phrase "[i]t's a free country, i'n'it?" meant only that "we could do what we liked as long as there was no law forbidding or preventing us".[136]

[112] Counsel for the Attorney-General also emphasised that the position in New Zealand is not like that of Canada where there is in s 7 of the Canadian Charter a guarantee of the right to liberty of the person, or that in the United Kingdom where art 8 of the European Convention protects the rights to a home life and a private life.[137]

[113] The latter submission would require consideration of the second of the stated purposes of the Bill of Rights, namely, to "affirm New Zealand's commitment to the International Covenant on Civil and Political Rights".[138] Article 9(1) of the Covenant protects the right to liberty and security of the person. But we do not need to decide whether there is a right to a home or private life in New Zealand. We can leave consideration of the place of concepts of liberty and of the right to a home or private life to another case. That is so because it is clear that, however concepts of residual liberty and the right to a home or private life are construed, on the facts of this case the right to smoke in an ICU in which the patient is lawfully placed is not included.

[114] At the time of the hearing before us, in England, Scotland, Australia and Canada, courts considering smoking bans in mental health or comparable institutions similarly concluded that the right to smoke is not protected by the right to a home or private life. A similar approach is taken to liberty in the United States. However, subsequent to the hearing, the Supreme Court of the United Kingdom delivered its

---

135 *R (Countryside Alliance) v Attorney General* [2007] UKHL 52, [2008] 1 AC 719.

136 At [112]. Baroness Hale noted that after the Human Rights Act 1998 (UK) came into force it was possible for the court to declare that a statute was incompatible with the Act: at [113].

137 Reference is made to the discussion of the Court of Appeal in *M v Minister of Immigration*, above n 131, at [20]: "the domestic law of New Zealand does not recognise a right to family life" though "family life is regarded by many as an important value in a general sense" and "may be recognised in particular statutory settings", or as a "relevant consideration in some immigration applications". See also *Helu v Immigration and Protection Tribunal* [2015] NZSC 28, [2016] 1 NZLR 298.

138 New Zealand Bill of Rights Act, long title, (b).

judgment in *McCann*[139] which, in allowing an appeal from the decision of the Second Division, Inner House, Court of Session in Scotland upholding the ban,[140] took a different view.

[115] As discussed above, the Court in *McCann* considered the legality of a comprehensive smoking ban at the State Hospital.[141] Importantly, the ban was also accompanied by a prohibition on the possession of tobacco products and procedures for the search and seizure of such products. The Court's conclusion the ban was illegal turned ultimately on the terms of the Scottish statutes in issue. The Court said the ban on smoking itself could be implemented as part of the power of management under the National Health Service (Scotland) Act 1978 (the 1978 Act). But, the Court found, the authority for the associated prohibition on possession and the power to search and confiscate had to be found in the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) and its associated regulations.[142] As a result, in implementing the ban the Hospitals Board was required to give consideration to the principles set out in s 1 of the 2003 Act and to comply with the obligations to inform and record in the accompanying regulations. Because the Board had mistakenly considered itself to be acting under the 1978 Act, it had failed to comply with these requirements.[143] On this basis the ban was held to be unlawful.

[116] Because the Court considered that it was "likely that the problem of compliance with the 2003 Act" and its accompanying regulations could be remedied,[144] it went on to consider whether the ban was inconsistent with art 8 of the European Convention on Human Rights.[145] Article 8 protects the right to respect for private and family life and provides in art 8(1) that "[e]veryone has the right to respect for his private and family life, his home and his correspondence". The Court found that the ban itself breached art 8, but that this breach was justified.

---

139 *McCann* (UKSC), above n 127.
140 *CM v State Hospitals Board for Scotland* [2014] CSIH 71, 2015 SC 112 [*McCann* (CSIH)].
141 See above at [103].
142 *McCann* (UKSC), above n 127, at [34].
143 At [39]–[40].
144 At [44].
145 Convention for the Protection of Human Rights and Fundamental Freedoms (opened for signature 4 November 1950, entered into force 3 September 1953).

[117] On the scope of art 8, Lord Hodge adopted[146] the description of Lord Bingham in *Countryside Alliance*, namely:[147]

> It is to protect the individual against intrusion by agents of the state, unless for good reason, into the private sphere within which individuals expect to be left alone to conduct their personal affairs and live their personal lives as they choose.

[118] Lord Hodge also noted there was authority in the jurisprudence of the European Court of Human Rights for the proposition the sphere of personal autonomy protected by art 8 could encompass activities that caused the individual harm.[148] The other relevant aspect of art 8 in issue was the protection it gave to the home.[149]

[119] The Supreme Court agreed with the lower Court on the first two stages of that Court's analysis, namely:[150]

> First, … a detainee's right to respect for private life extended only to protection against interference beyond the concomitants of lawful detention. [Second] … that institutions such as the State Hospital would be unmanageable without some restriction of the scope of the right to respect for private life of detained persons "to that beyond the ordinary restrictions pursuant to lawful detention".

[120] The Court, however, took issue with the third step in this analysis, that is, the finding that the ban "did not have a sufficiently adverse effect on a person's physical or psychological integrity or [the] right to personal development as to merit protection".[151]

[121] In reaching that view, Lord Hodge said that whilst in long-term detention constraints on liberty were inevitable, the result was that the Court had to "assiduously … uphold the right to respect for what little remains" of the private sphere.[152]

---

146 *McCann* (UKSC), above n 127, at [45].
147 *Countryside Alliance*, above n 135, at [10].
148 *McCann* (UKSC), above n 127, at [46]; citing *Pretty v United Kingdom* (2002) 35 EHRR 1 (Section IV, ECHR) at [62].
149 At [47].
150 At [49].
151 At [49].
152 At [50]. See also at [53].

[122] In deciding the ban was nonetheless a justified limit on art 8, Lord Hodge considered the ban was rationally connected to a legitimate objective, namely:[153]

> … to protect the detained patient from the health risks of his smoking and other people from the health risks of second-hand smoke. The comprehensive smoking ban clearly has a rational connection with the pursuit of that desirable goal.

[123] The Court was also satisfied the ban was a proportionate response.[154]

[124] We note also that in *R (N) v Secretary of State for Health* the England and Wales Court of Appeal dealt with a smoking ban in a high security psychiatric hospital managed by an NHS Trust and established by the Secretary of State for Health.[155] The smoking ban was very similar to that of the WDHB. The majority, Lord Clarke MR and Moses LJ, concluded that art 8 of the European Convention on Human Rights was not engaged by the smoking ban and, in any event was a justified limit on the right.

[125] In dissent, Keene LJ drew from the *Countryside Alliance*[156] case that the concept of personal life was a broad one.[157] Smoking was a pastime valued by those who smoke and the need for protection was seen as:[158]

> … all the more appropriate where the activity in question is taking place in the person's home or in some other institution where he or she resides for a substantial amount of time.

[126] Keene LJ found that the ban did amount to a breach of art 8.[159] As against the Secretary of State, Keene LJ concluded that the ban was not justified because it was a disproportionate response. A different position was reached in relation to the NHS Trust. There, Keene LJ noted that the extent of staff supervision needed to allow dangerous patients into the grounds so as to smoke and the high cost of that

---

153 At [59].
154 At [60].
155 *R (N) v Secretary of State for Health*, above n 100.
156 *Countryside Alliance*, above n 135.
157 *R (N) v Secretary of State for Health,* above n 100, at [98].
158 At [101].
159 At [108].

process made the Trust's decision not to allow that to happen reasonable and proportionate.[160]

[127] In Australia, in *De Bruyn v Victorian Institute of Forensic Mental Health*, the plaintiff was an involuntary patient at a hospital which was a clinical services facility of the defendant, the Victorian Institute of Forensic Mental Health.[161] Again, the ban was a complete one with no smoking permitted on the premises or in outdoor areas. Cigarettes and other associated matter were treated as contraband.

[128] Riordan J in the Supreme Court of Victoria said there was a right to smoke in the sense that the plaintiff has a right to "do what he pleases, provided he does not transgress the substantive law, or infringe the legal rights of others".[162] Riordan J considered there was no inconsistency between the ban and s 22(1) of the Charter of Human Rights and Responsibilities Act 2006 (Vic) which protected the rights of those deprived of liberty to be treated with "humanity and with respect for the inherent dignity of the human person".[163] In reaching that view, the Judge looked at considerations on both sides, for example, the psychological effects of withdrawal and the impact of that on a plaintiff with a mental condition on the one hand and, on the other, the fact that the policy had been introduced with a programme making NRT and other treatments available to the patients to ameliorate the withdrawal symptoms.[164]

[129] In Canada, La Forest J in *Godbout v Longueuil (City)* discussed the scope of the right to liberty in s 7 of the Charter.[165] He said:[166]

> … the right to liberty enshrined in s. 7 of the *Charter* protects within its ambit the right to an irreducible sphere of personal autonomy wherein individuals may make inherently private choices free from state interference. … I do not by any means regard this sphere of autonomy as being so wide as

---

160 At [111].

161 *De Bruyn v Victorian Institute of Forensic Mental Health* [2016] VSC 111, (2016) 48 VR 647.

162 At [94].

163 At [131].

164 At [128]–[129].

165 *Godbout v Longueuil (City)* [1997] 3 SCR 844.

166 At [66]. This approach was affirmed by the Supreme Court of Canada in *Blencoe v British Columbia (Human Rights Commission)* 2000 SCC 44, [2000] 2 SCR 307 at [49] and [54]. See also Hamish Stewart *Fundamental Justice: Section 7 of the Canadian Charter of Rights and Freedoms* (Irwin Law, Toronto, 2012) at 68; and Robert Sharpe and Kent Roach *The Charter of Rights and Freedoms* (5th ed, Irwin Law, Toronto, 2013) at 235–236.

> to encompass any and all decisions that individuals might make in conducting their affairs. … Moreover, I do not even consider that the sphere of autonomy includes within its scope every matter that might, however vaguely, be described as "private". Rather, as I see it, the autonomy protected by the s. 7 right to liberty encompasses only those matters that can properly be characterized as fundamentally or inherently personal such that, by their very nature, they implicate basic choices going to the core of what it means to enjoy individual dignity and independence.

[130] In a judgment of the Ontario Superior Court of Justice, Pitt J rejected a claim of inconsistency with s 7 of the Charter brought by a long-term smoker against a smoking ban.[167] The applicant had been found not guilty by reason of insanity and was detained in a mental health centre on a long-term basis. Pitt J said there was no constitutional right to smoke. The Judge saw the analogy as being with the ability to use alcohol or other substances. Pitt J approached the case on the basis that s 7 included the protection of personal autonomy. But, the Judge concluded:[168]

> While the smoking ban does affect the applicant's autonomy, in so far as it limits his choice to smoke, I am not persuaded that the ban affects decisions of fundamental importance. Similarly, while the ban may well result in psychological stress, I cannot find that it has caused "serious state-imposed psychological stress".

[131] A similar approach to "liberty" is reflected in *Obergefell v Hodges* in which the Supreme Court of the United States confirmed liberties "extend to certain personal choices central to individual dignity and autonomy, including intimate choices that define personal identity and beliefs".[169]

[132] In our view, the notion that a right to a home or private life includes the right to smoke whilst confined for very short periods in the ICU of a mental health institution is too generalised because it is too removed from the sphere of personal autonomy warranting protection. In terms of the position of the appellant in the present case, whilst in the ICU there are inevitably some constraints on a patient's choices, for example, in terms of what they may eat and drink.

---

167 *Vaughn v Ontario* (2003) 115 CRR (2d) 36 (Ont SCJ).
168 At [20].
169 *Obergefell v Hodges* 135 S Ct 2584 (2015) at 2597.

[133] We see *McCann* as involving two distinguishing features from this case.[170] First, Mr McCann was detained in the hospital on a long-term basis ("without limit of time") as part of the disposition of criminal charges against him. He was not able to smoke at all during his detention.[171] By contrast, as we have noted, the total smoking ban applied only to the appellant during his relatively short periods in the ICU albeit multiple admissions are possible. The length of time he spent in the ICU is consistent, as we have also observed earlier, with the average length of stay in the ICU.

[134] Second, we have evidence before us as to both the positive effects of even short-term cessation of smoking as well as on the harm caused by smoking in mental health facilities. In addition, we have the benefit of the evidence we have discussed about NRT. The Court in *McCann* does not appear to have had evidence on these topics, and, certainly, nothing of the nature of the evidence before us. The effect of this evidence is to indicate smoking, at least in the context of a short-term ban, can be put in the category of harmful activities appropriately constrained in the mental health institutions in issue here. The right in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 to have his or her privacy respected which was relied on by the appellant in the further written submissions does not add materially to the analysis for the same reason.[172]

[135] Even if there is a breach, we are satisfied that, applying the analysis adopted in relation to the right to be treated with humanity and with respect for dignity (s 23(5)), the 2009 smoke-free policy is a reasonable and proportionate one which would comprise a justified limit under s 5 of the Bill of Rights. The approach of the Supreme Court of the United Kingdom in *McCann* supports that conclusion.[173]

---

170 *McCann* (UKSC), above n 127, at [2].

171 *McCann* (CSIH), above n 140, at [11]. By the time of the hearing in the Court of Session, Mr McCann had been transferred to a medium secure unit: at [12].

172 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations, cl 2, right 1(2). Clause 3 provides that a provider is not in breach of the Code where "reasonable actions" have been taken in the circumstances to give effect to the rights and comply with the duties in the Code.

173 See above at [122]–[123].

[136] We consider the Courts below were correct to conclude there is no existing right to smoke as contended for by the appellant.

Decision

[137] For these reasons the appeal is dismissed. As was the case in the Court of Appeal the respondent did not seek costs. In the circumstances, it is appropriate that costs lie where they fall. There is no order as to costs.

Solicitors:
Warren Simpson, Papakura for Appellant
Claro, Wellington for Respondent
Crown Law Office, Wellington for Intervener