OUTER HOUSE, COURT OF SESSION

[2018] CSOH 4

P1332/15 & P1038/15

OPINION OF LADY CARMICHAEL

In the petition of

A & B

Petitioners

against

NHS GREATER GLASGOW & CLYDE HEALTH BOARD

Respondents

Petitioners: Leighton; Drummond Miller LLP
Respondents: Campbell QC; NHS Scotland Central Legal Office

26 January 2018

[1] The Supreme Court considered the lawfulness of the imposition of a complete ban on smoking tobacco at the State Hospital in *M* v *State Hospitals Board for Scotland* 2017 SLT 451. The Supreme Court allowed the appeal in part. It held that the comprehensive ban did not of itself breach the appellant's rights under Article 8 ECHR or under Article 8 read with Article 14. The ban was, however, accompanied by a prohibition on patients' possession of tobacco products, with associated confiscations and searches. That prohibition with the power to search and confiscate products was found to be unlawful. That was because those matters fell within the scope of the Mental Health (Care and Treatment) (Scotland) Act 2003

("the 2003 Act") and the Mental Health (Safety and Security) (Scotland) Regulations 2005 ("the 2005 regulations").

[2] These two petitions relate, respectively, to the imposition of complete bans on smoking tobacco in the Rowanbank Clinic ("Rowanbank"), which is a medium secure hospital, and Leverndale Hospital ("Leverndale"), which provides, amongst other psychiatric services, a low secure forensic psychiatric in-patient facility. Mr A is detained in Rowanbank, and Mr B is detained in Leverndale. Both hospitals are operated by the respondents.

[3] The petitioners contend that the comprehensive prohibition on smoking engages Article 8 ECHR, and is unlawful because it is not proportionate. They say that the decision of the Supreme Court falls to be distinguished because particular circumstances relevant to the State Hospital, but not to Rowanbank or Leverndale, informed the conclusion that the prohibition in *M* was a proportionate measure. They argue also that the respondents failed to give adequate reasons for introducing the prohibition.

[4] The petitions raise issues not raised in *M* regarding the responsibilities of the respondents under the Equality Act 2010 ("the 2010 Act"). They also, particularly B's petition, raise questions as to the scope and effect of the decision in *M* as to the means by which prohibitions on the possession of items by detained patients may lawfully be effected.

[5] I was told that the point on which the petitioner and appellant in *M* succeeded in the Supreme Court was not one which had featured in the case of either party to that appeal, and which had not featured in discussion in the courts below. It was one which had emerged in the course of the oral debate during the hearing of the appeal. Against that background I was provided with some materials which I understand were not before the Supreme Court.

[6] Mr A's petition pre-dates the requirement for permission in judicial review proceedings. Mr B's petition does not. It was sisted for a period pending the outcome of the appeal in *M*. Mr B was allowed to amend the petition to reflect the decision in *M* and to impugn "the decision to ban tobacco and related powers" under the 2003 Act and the 2005 regulations: paragraph 7 of the Opinion of Lord Burns dated 10 August 2017 granting permission to proceed on certain specified grounds. Lord Burns granted permission to proceed in respect of the comprehensive ban on the grounds of breaches of provisions of the Equality Act 2010, and of Article 8 ECHR; and in respect of the "ban on possession". He refused permission to proceed in respect of the comprehensive ban on the grounds of insufficient consultation; inadequate reasons; and unlawfulness under the 2003 Act.

Article 8 ECHR

[7] From March 2008 until October 2015 the respondents allowed some smoking in the grounds of mental health hospitals. In October 2015 they introduced a comprehensive ban, prohibiting smoking, so far as is material for these petitions, in the grounds of Rowanbank and Leverndale. The ban is not confined to facilities accommodating "forensic" patients (those who, like the petitioners, are subject to compulsion by virtue of compulsion orders made by a criminal court), but extends to all the mental health hospitals for which the respondents have responsibility. The State Hospitals Board had already imposed a comprehensive ban on smoking, having made a decision to do so in August 2011, to have effect from December 2011.

[8] Several issues are no longer contentious following the decision in *M*. The petitioners accept that the comprehensive ban on smoking results from an exercise by the respondents

of their powers of management. The respondents accept that Article 8 is engaged: *M*, paragraphs 49 to 57.

[9] Mr Leighton asked me to assess proportionality using the approach set out by Lord Reed in *Christian Institute* v *Lord Advocate* 2017 SC (UKSC) 29, at paragraphs 90, 93, and 94. That involved addressing questions: (i) whether the objective is sufficiently important to justify the limitation of a protected right; (ii) whether the measure is rationally connected to the objective; (iii) whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective; and (iv) whether, balancing the severity of the measure's effects on the rights of the persons to whom it applies against the importance of the objective, to the extent that the measure will contribute to its achievement, the former outweighs the latter (ie whether the impact of the rights infringement is disproportionate to the likely benefit of the impugned measure).

[10] He did, however, seek to depart from Lord Reed's exegesis of the third question, at paragraph 93, which is in the following terms:

> "The third question (whether a less intrusive measure could have been used) does not involve a court in identifying the alternative legislative measure which was least intrusive. The court allows the legislature a margin of discretion and asks whether the limitation on the fundamental right is one which it was reasonable for the legislature to impose."

[11] Mr Leighton submitted that where the decision-maker was not a legislature it would be open to the court to identify the alternative measure which was least intrusive. He said that that would be a relatively simple task in the present case. Broadly speaking, he suggested that the alternative measure was one which allowed smoking outdoors.

[12] In advancing his submissions about proportionality, Mr Leighton drew attention to an apparent divergence in the approach of the Scottish Government from that of the respondents regarding smoking in psychiatric hospitals. He made reference to two

statements by ministers, one in the context of the passage of the Smoking, Health and Social Care Act 2005 ("the 2005 Act"), and another in the context of the passage of the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 ("the 2016 Act"). He made reference to the Stage 1 report of the Health Committee regarding the bill that became the 2005 Act, and to the policy memorandum and delegated powers memorandum accompanying the bill that became the 2016 Act. Mr Campbell submitted that reference to these passages was inadmissible in assessing the proportionality of the ban, under reference to *Wilson* v *First County Trust Ltd (No 2)* [2004] 1 AC 816, particularly paragraphs 61 to 67, *per* Lord Nicholls of Birkenhead. He submitted, also, that even if admitted, the material was irrelevant.

[13] Mr Leighton referred to a passage in the official record of the proceedings of the Health Committee on 22 March 2005, at col 1838, when Mr Andy Kerr, then Minister for Health and Community Care, answered a question regarding exemptions from the provisions of the bill. He referred also to the Health Committee's Stage 1 report on the same bill, particularly at paragraphs 25 and 26, although those do not specifically refer to exemptions. Paragraphs 33 to 38 do deal with exemptions, on the basis that certain exemptions ought to be permitted, provided the premises in question had a smoking policy.

[14] Paragraphs 90 and 91 of the policy memorandum relating to the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill included reference to the powers in the bill to make exemptions, in relation, for example, to psychiatric hospitals. Paragraph 94 of the Delegated Powers memorandum again refers to the power to make exemptions in respect of premises including psychiatric hospitals.

[15] Finally, in this chapter of submission, Mr Leighton referred to an answer given by Maureen Watt, then the Minister for Public Health, and recorded in the official report of 6 October 2015 at col 5. The question was this:

> "If there is a patient who staff believe should be allowed to smoke for their own wellbeing, and a staff member takes them outside and allows them to smoke, would that staff member be breaking the law?"

The answer was:

> "… I suspect that you are thinking of people who are in mental health wards or long-term patients who have gone on smoking. In the case of people who are going in for an operation, we are trying to make sure that they are made aware of the smoking policies at the initial appointment with their consultants and are offered smoking cessation services before they go for their operation.
>
> Areas will be set aside for people who have mental health issues to smoke. However the overarching policy will be to encourage people to stop smoking, because smoking does not contribute anything towards mental health and wellbeing, it actually does the opposite."

[16] Mr Leighton submitted that in assessing whether the respondents' imposition of a comprehensive ban was proportionate, it was relevant to take into account that the executive and the legislature had throughout the whole development of legislation restricting the right to smoke in public places taken the view that it remained appropriate to exempt psychiatric hospitals. Mr Leighton's point was that the Scottish Government's and Scottish Parliament's continued recognition of a need for psychiatric hospitals to be exempt from these provisions tended to indicate that the respondents' comprehensive ban on smoking was disproportionate and unlawful.

[17] He submitted that the legislation and related documents had not featured in discussion in *M*. While it is correct that the 2016 legislation and related material were not the subject of discussion in *M*, the argument that the comprehensive ban on smoking was contrary to Scottish Government policy certainly was. It was the subject of discussion and

decision by the Lord Ordinary and the Inner House. The argument does not appear to have been pursued in the Supreme Court.

[18] In addition to making the submissions just referred to, Mr Leighton sought to distinguish the decision in *M* on the grounds, first, that there was no document in the present case equivalent to the minute of the meeting of the State Hospitals Board referred to in *M* at paragraph 12, and, second, that the security considerations which favoured a comprehensive ban in *M* were less acute in medium and low secure settings such as Rowanbank and Leverndale. On that point also he referred to *R(G)* v *Nottinghamshire NHS Trust* [2010] PTSR 674 at paragraph 69, where, in the context of the smoking ban at Rampton Hospital, security requirements were found to be relevant.

[19] Both petitioners provided affidavits in which they confirm that they wish to smoke. Mr A states that he is aware that smoking is bad for his physical health, but he wishes to be able to continue smoking because he enjoys it. Mr B says that he stopped smoking for a period of eight and a half years but restarted because he felt that smoking helped his anxiety. He does not feel that there is any benefit to his health as a result of being forced, as he put it, to give up smoking. He enjoys smoking and wishes to continue to do so.

[20] In relation to Mr A, Mr Leighton drew attention to the annual report of his responsible medical officer ("RMO") dated 10 December 2015. It records that at the time of writing, Mr A's mood was generally stable. At the beginning of October 2015 there had been a deterioration in his mood which manifested itself in his becoming verbally hostile with staff and getting into arguments with them. This had resulted in "something of a deadlock in the therapeutic relationship". He was subject to particular measures detailed in the letter for a period of 48 hours and seemed then to show some improvement. He was started on a mood stabilising drug. Later in the report, the RMO reports that Mr A had been

unsettled over the previous six months, and that his time out of the ward had been curtailed due to his behaviour and his tendency to anger over what were sometimes trivial matters. He had been particularly angered by the cessation of smoking protocol which had come into effect in October 2015. He had had assistance from clinical psychology with respect to helping him "regain control" over his mood and behaviour, and the medication already referred to was assisting further. Mr Leighton submitted that this further demonstrated the importance to Mr A of retaining the opportunity to smoke in the grounds of the hospital.

[21] Mr Campbell referred to the duty imposed on the Scottish Ministers by section 1 of the National Health Service (Scotland) Act 1978 to promote in Scotland a comprehensive and integrated health service designed to secure (a) improvement in the physical and mental health of the people of Scotland, and (b) the prevention, diagnosis and treatment of illness, and for that purpose to secure the effective provision of services in accordance with the provisions of the Act. Section 1A imposed a duty on the Scottish Ministers to promote the improvement of the physical and mental health of the people of Scotland. Section 2 however, made it clear that it was health boards such as the respondents who were charged with carrying out certain of the functions of the Ministers under the 1978 Act. Section 2A(1), imposed directly a duty on each health board to promote the improvement of the physical and mental health of the people of Scotland. Section 2A(2) provided that a health board may do anything which they consider is likely to assist in discharging that duty. Section 2A(4) provided that anything done by a health board in pursuance of section 2A(1) was to be regarded as done in exercise of the functions of the Scottish Ministers conferred on the board by the order constituting it.

[22] Mr Campbell acknowledged that there was no single document in this case which recorded the decision to impose a comprehensive smoking ban. He referred to an affidavit

by Dr Linda de Caestecker, the respondents' executive director for public health; to the respondents' *Smokefree Policy*, dated May 2014; and to two documents referred to in the *Smokefree Policy*. Those were *Smokefree mental health services in Scotland – Implementation guidance* produced by NHS Scotland in 2011, and *Creating a Tobacco-Free Generation – A Tobacco Control Strategy for Scotland*, produced by the Scottish Government in 2013. He referred, finally, as did Mr Leighton, to the *Comprehensive Smoke Free Implementation Plan* issued by the Directorate of Forensic Mental Health and Learning Disabilities in August 2015. Mr Campbell did not seek to rely on it as containing reasons for the respondents' decision, pointing out that it post-dated the decision to impose the comprehensive prohibition.

Dr de Caestecker's Affidavit

[23] The petitioners did not dispute the content of Dr de Caestecker's affidavit. It narrates that she is the strategic lead for the respondents in all issues relating to tobacco and smoking, and that she chairs the tobacco planning and implementation group ("TPIG"). The smoke free policy is a health and safety responsibility, but as the policy relates to a health improvement topic, its development is managed by two directorates, that for public health and that for health and safety.

[24] The TPIG reported to a board-wide planning group, which reported to the corporate management team ("CMT") of the respondents. The TPIG had representatives from each of the divisions within the respondents, and met quarterly.

[25] At paragraphs 10 and 11 of the affidavit, Dr de Caestecker explains:

> "10. Prior to the exemption being removed in 2015, forensic services had been progressing towards their facilities and grounds becoming smoke-free in 2013. They made a decision to move towards being smoke-free and held

> consultations with patients and staff. Forensic services took their proposals through clinical governance and senior management team. They also considered the ban on smoking in grounds at the State hospital and as a result made the decision to go entirely smoke-free, initially implementing periods of time during the day when the grounds were smoke-free and gradually increasing these.
>
> […]
>
> 11. Forensic services delayed the implementation of smoke-free grounds as the smoke-free policy at that time still exempted mental health patients. A further reason for the delay was that the decision taken by forensic services to go smoke-free had not yet been considered by the TPIG. The Group also paused implementation as the Board were aware of the issues arising from the State hospital case [*M*] in 2013. Having considered all these issues, forensic services decided to wait for mental health grounds to go smoke free as a whole, as part of the NHS Board process, rather than implement smoke-free independently."

[26] The affidavit contains details of the various teams within the respondents' organisation, and the process for reviewing the tobacco policy. I do not reproduce those passages in full here. In summary, the TPIG identified a need to review the 2011 to 2014 policy. A group was established to review that, with a limited consultation. During the consultation, feedback was received from the medical director for mental health, and the director for mental health, stating their view that the exemption for mental health should be removed on the basis of equality and the contribution of smoking to the poor health of those with mental health issues (paragraph 17 of affidavit). This amendment to the policy, along with others, was included in an email on 20 February 2014 from the director of human resources to the members of the CMT asking for comment and approval. A date by which responses should be provided was included in the email. No comments were received. The proposal was then circulated to the CMT (paragraph 18 of affidavit). It was the CMT that took the decision regarding a comprehensive prohibition on smoking.

[27] At paragraph 22, Dr de Caestecker states:

"The Board have a close relationship with the national tobacco policy makers at The Scottish Government. The Board always responds to any formal consultations on tobacco control issues and responded to The Scottish Government consultation on the national tobacco strategy, Creating a Tobacco-free generation. Any new national tobacco policies or strategies are taken to the TPIG to review the implications for the NHS Board. The minutes from the TPIG will show this. Fiona Dunlop as Lead for Tobacco then co-ordinates actions to address issues arising and reports on progress to the TPIG. Discussion relating to these Government documents is included in the TPIG minutes."

[28] At paragraphs 23 to 27 she provides information about the considerations in the mind of the respondents so far as the grounds of mental health hospitals were concerned:

"23. The move to smoke-free in mental health grounds progressed more slowly than for other acute areas, recognising the challenges presented in mental health. Initially in the 2011-2014 policy, mental health grounds were exempt and we provided external smoking areas. However, we were concerned that this exemption was unfair and that it continued to expose mental health patients and staff to the harm associated with smoking. This was a particular concern given the high levels of smoking and poor health of mental health patients. The message we wanted to communicate was that the Board was concerned about the impact of smoking on all patients, visitors and staff including mental health. The external smoking areas provided were removed in 2015.

24. The Board were aware of concerns raised about exempting mental health patients from the smoke-free policy and the potential that this would contribute to the stigma of mental health patients. The Board had received communication from a third sector service, "VOX" outlining various concerns including their concerns about removing the exemption for mental health patients. Rebecca Campbell, the then Health Improvement Lead for Tobacco had responded advising that by removing the exemption the Board were protecting the health of mental health patients who were to be treated equally; that the Board were aware of the needs and anxiety of mental health patients and that their physical health is much poorer with a lower life expectancy. The Board's responsibility is to keep these patients as healthy as possible.

25. The Board has particular regard to the effect of smoking on members of staff. The Board were extremely concerned about the members of staff affected by smoking when exposed by patients and as part of the formation of policy, the intention of the Board was to protect the health of their mental health staff. There were several meetings in which the Board weighed up the rights of patients to smoke with the rights of staff not to be exposed to smoke. Health risks to non-smoking staff very much influenced the Board's decision to

implement a comprehensive smoke-free policy, in addition to their strong concerns relating to the health of non-smoking patients.

26. Ahead of the implementation of the smoke-free policy, a consultation took place in Forensic Services in 2013 with current smokers in Leverndale secure services and at Rowanbank. Forensic services also consulted with Carers groups. James Mead and Jennifer Wyld were involved in this; the TPIG were not a party to it and were not directly involved in the consultation. With respect to the 2015 policy change, we only undertook a limited consultation as this issue had been considered previously when forensic services were considering the move to smoke-free in 2013.

27. Although the Board's smoke-free policy was put into place in 2014, it only applied to mental health patients from 1 October 2015. It was implemented in line with the Board's Comprehensive Smoke Free Implementation Plan dated August 2015."

[29] At paragraph 31, Dr de Caestecker states that an additional influencing factor was that there was a comprehensive ban on smoking at the State Hospital. It was a concern to the respondents to ensure continuity for patients leaving the State Hospital when moving on to the medium secure environment at Rowanbank, so that they might continue to be in a smoke-free setting.

Smokefree Policy – May 2014

[30] The respondents' *Smokefree Policy* was approved in May 2014 by the respondents' CMT and health and safety forum. Mr Campbell submitted that it was the document most closely approximating to a written record of the impugned decision in the present case. It narrates:

> "From March 2008 mental health hospitals and units were permitted to have external smoking areas, subject to certain conditions laid out in previous Policy documents. The organisation now aims to have smokefree grounds at mental health hospitals and units by October 2015."

The document goes on to record at paragraph 1.2 the well-known adverse effects on health of smoking tobacco, both for the smoker and for others exposed to smoke. It refers to the

responsibilities of the respondents for the health of patients, staff, visitors and contractors, and in relation to the provision of a safe, healthy working environment. It refers to the Scottish Government document *Creating a Tobacco-Free Generation – A Tobacco Control Strategy for Scotland* in the following terms:

> "[the Scottish Government document] requires all NHS Boards to have a well implemented Smokefree Policy, covering buildings and grounds. An effectively implemented NHS Smokefree Policy shows good leadership and demonstrates an exemplar role in public health and can play a key part in reducing the health impact of tobacco."

It goes on:

> "A clear message will be provided that smoking, and second hand smoke, is a major cause of preventable ill-health and should be discouraged. We will highlight the support that the now well-established stop smoking services can offer to staff or patients who wish to stop smoking. A recent research paper published in the British Medical Journal (BMJ 2014 – see reference documents) considered changes in mental health after smoking cessation. The paper concluded that smoking cessation is associated with reduced depression, anxiety and stress and improved positive mood and quality of life compared with continuing to smoke. This research has been taken into account when considering smokefree grounds in Mental Health facilities.
>
> Improving the health of our population is a key aim within NHS Greater Glasgow and Clyde, and compliance with this Policy will contribute greatly to the much needed reduction in prevalence of smoking and exposure to tobacco smoke. A smokefree environment and the provision of tobacco education and stop smoking support are recognised methods of achieving this aim, all of which are at the heart of this Policy.

1.3 Aim

The aim of this Policy is to create a smokefree, healthy and safe environment for staff, patients and visitors to work and visit. This Policy will also work towards the national requirement to have all grounds smokefree by 2015. This is fundamental to NHS Greater Glasgow and Clyde's desire to be a responsible employer, and to fulfil its health improvement role.

1.4 Key principles

- No patient, visitor or staff member should be exposed to tobacco smoke against their will.

- It is tobacco smoke, and its effects on those who use it and are exposed to it, that is the problem rather than the smokers themselves.

- Smokers who want to stop will be offered stop smoking support; those experiencing withdrawal will be treated in a supportive way.

- All patients who smoke will be sensitively offered NRT [nicotine replacement therapy] to relieve withdrawal symptoms whilst they are in our care and unable to smoke.

1.5 Equality and Diversity
The application of this Policy will be monitored by the Director of Human Resources to ensure equitable treatment of all employees irrespective of sex, race, age, disability, sexual orientation, ethnic origin, religion or belief.

Policy in Practice
…

2.2 Exceptional circumstances (until October 2015)
Exemptions do not constitute a right to smoke – NHS Greater Glasgow and Clyde is bound by a duty of care to protect its employees.

Mental health patients: from March 2008 external smoking areas have been utilised for Mental health inpatients. The remainder of the grounds in these hospitals must be maintained smokefree for all. The organisation is now committed to the removal of external smoking areas, with the aim of having smokefree grounds at Mental health hospitals and units, by **October 2015**.

Until October 2015, any permitted external smoking area, as referred to above, must meet the following criteria …."

Appendix A of the Policy refers to a variety of legislation, mainly relating to health and safety at work, but also to the Disability Discrimination Act 1995. In addition to the Scottish Government document and the BMJ article already referred to, there is a reference to *Smokefree mental health services in Scotland – Implementation guidance* produced by NHS Scotland in 2011 ("the 2011 guidance").

The 2011 Guidance

[31] The document is one focused on the eradication of smoking indoors at mental health facilities. The respondents had themselves by its date already prohibited smoking indoors in mental health hospitals, and the State Hospitals Board was in 2011 in the process of

imposing a comprehensive ban, including the grounds. It acknowledges that some mental health hospitals already had relevant policies: eg at page 2. Despite its particular focus, however, it contains material potentially relevant to decisions to prohibit smoking in mental health hospitals. At page 3, for example, it reads:

> "Stakeholders interviewed for this guidance who have already introduced smoke-free policies to mental health hospitals and wards identified three reasons for doing so:
>
> - People with mental health problems should not be treated in a different way to other members of the public in terms of looking after their physical health. Continuing to permit smoking in mental health institutions perpetuates inequalities in the treatment of mental health problems.
>
> - People with mental health problems are not allowed to smoke in public places when they live outside mental health hospitals, and allowing them to smoke in mental health hospitals stigmatises them as different.
>
> - Staff do not wish to be subjected to passive smoking and the associated harmful impacts on their physical health. Staff in other workplaces in Scotland are not expected to work in environments where they breathe in second-hand smoke."

At page 4 it continues:

> "**Facts about smoking and mental health**
>
> - People with mental health problems are more likely to smoke; to be more nicotine dependent; to have smoked for longer; and to smoke more heavily than the general population (Campion *et al*, 2008a).
>
> - Contrary to popular opinion, smoking is harmful to mental health. Smoking increases the risk of developing a mental health problem, with a clear relationship identified between the amount of tobacco smoked and the number of depressive and anxiety symptoms in people with existing mental illness and those without mental health problems (Faculty of Public Health, 2008).
>
> - The high levels of smoking among people with serious mental health illness, combined with the fact that around one in two smokers dies prematurely, mean that the death toll from smoking far outweighs the 10% lifetime risk of suicide (Campion *et al*, 2006).

Heavy smoking is associated in particular with schizophrenia. Nicotine in cigarettes appears to be especially reinforcing in people with schizophrenia, as it stimulates the subcortical reward system and the prefrontal cortex, both of which appear to be hypofunctional in people with schizophrenia (Chambers *et al*, 2001). Whilst there are many reports in previous literature of nicotine helping to alleviate some of the negative symptoms of schizophrenia (eg Patkar *et al*, 2002), the medical evidence on smoking as self-medication remains inconclusive. There does seem to be a complex interaction between nicotine dependence and schizophrenic symptoms (Aguilar *et al*, 2005), but a systematic review found no randomised clinical trials that support the self-medication hypothesis (Punnoose and Belgamwar, 2006)."

Pages 9 to 10 contain lists of benefits to mental health service users and to the organisations and staff providing them with services of those users' stopping smoking:

"**Benefits to mental health service users of quitting smoking**

- Improved physical health/wellbeing.
- Improvement in mental health – fewer neurotic disorders.
- Increased sense of self esteem.
- Reduction in service user stress levels.
- More consistent serum levels due to removal of fluctuations in nicotine levels.
- Liberation from addictive and harmful substances.
- Possible reduction in dosage of medication.
- Improvement in finances.
- More integration between service users and staff due to reductions in segregation of smokers.
- More social contact for non-smokers who may previously have been marginalised from the social centre of the ward.

Benefits were also identified for organisations and staff:

Benefits to organisations and staff of mental health service users quitting smoking

- Presents the image of a health-promoting organisation.
- Provides staff with a smoke-free working environment, which reduces their exposure to second-hand smoke.

- Provides staff who smoke with a working environment conducive to helping them quit smoking.
- Cleaner work environment.
- Provides staff with the opportunity to work with service users in new ways which do not revolve around the negotiation of smoking rights.
- Increase in staff satisfaction with their work.
- Potential savings in medication costs (although possibly offset by increases in outdoor cleaning, depending on type of policy implemented"

Page 16 sets out considerations favouring a comprehensive, rather than a partial, smoke-free policy:

"**Comprehensive or partial smoke-free policy?**

Your decision on whether to introduce a comprehensive or a partial smoke-free policy will reflect your local circumstances and challenges. Guidance from the Health Development Agency in England (2005) refers to smoke-free buildings and grounds as the 'gold standard' policy and suggests that there are several reasons why hospitals should aim for this:

- Communicates a strong message about the dangers of smoking.
- Creates a smoke-free environment for people trying to stop smoking and removes triggers that cause many to smoke or relapse into smoking.
- Avoids problem of deciding where smokers can smoke outside.
- Avoids problem of smokers congregating at entrances to buildings.
- Avoids problem of smoke drifting into buildings through entrances and windows.
- Resources deployed on smoking shelters and cleaning litter could be better spent ensuring treatment is readily available.
- When smoking is allowed anywhere on the premises the risk of fires breaking out remains.

Interviews with stakeholders in Scottish mental health hospitals and wards with partial smoke-free policies in place have discovered that moving smoking outside into their grounds creates new problems relating to:

- Litter.
- Cleaning costs.
- Demands on staff to escort service users to and from shelters.
- Negotiations over times when smoking is permitted.
- Perceived intimidation of both service users and staff around the smoking shelter areas (more of a problem where the setting is low security and therefore more open to the public).
- Vandalism to smoking shelters.
- Breaching of rules relating to where smoking is permitted.
- Enforcement of the policy rules when the weather is poor.
- Maintenance of routes to and from smoking shelters.

The prevalent message from previous international experience is that comprehensive smoke-free policies are more effective than partial policies in terms of adherence to the policy and present mental health hospitals with fewer problems overall."

At pages 18 to 19 the document sets out potential disadvantages of introducing exceptions to smoke-free policies, and possible, albeit limited, bases on which such exceptions might be justified:

"**Exceptions to the rules?**

Past experience indicates that introducing exceptions to smoke-free policy rules hampers the overall effectiveness of the policy. Where exceptions are made, staff can be drawn into negotiations with service users over exception decisions, with possibilities for conflict arising over what could be seen as service user smoking privileges. Previous studies (e.g. Lawn and Pols, 2005; Leavell *et al*, 2006) concluded that simple smoke-free policies applied in a consistent way to all service users were most effective and reduced the likelihood of complaints and verbal aggression associated with selective policies.

Stakeholders in Scotland interviewed for this guidance favoured the no-exception approach:

Arguments against exceptions

- Creating exceptions will stigmatise certain service users.
- Exceptions to smoke-free policies are not made in the community.
- Exceptions work against 'normalisation' of service users.
- Difficult to agree basis on which exceptions can be made.
- Could be open to exploitation and manipulation.
- Consistency in application of a policy is its key to success; exceptions create inconsistency.

If you decide to permit exceptions to your smoke-free policy in exceptional circumstances, you will need to decide on the criteria for these. NHS guidance in England is for no 'blanket' exceptions for groups of service users, but decisions to be made for individuals on a case by case basis. Stakeholders in Scotland urge that any policy decisions on exceptions to smoke-free policies are communicated very clearly to staff so they adopt a consistent approach. Common views from the stakeholders interviewed, and from experience elsewhere, suggest that exceptions could be made using the following ground rules:

Possible ground rules for permitting exceptions

- No need for any exceptions where a partial smoke-free policy is in operation.
- Where a comprehensive policy is operating, use only where the circumstance is exceptional. This may be where the service user has been detained under the Mental Health Act and is in a dangerously heightened state of anxiety; where the service user is unable to understand the policy or agree to NRT; where NRT is temporarily unavailable; where a service user is in 'end of life' care.
- Where a comprehensive policy is operating, the first option should still be NRT, and smoking should still not be allowed in buildings."

Creating a Tobacco-Free Generation – A Tobacco Control Strategy for Scotland ("the 2013 policy")

[32] This is a document produced by the Scottish Government in 2013. Chapter 5 is entitled "Protecting People from Second-hand Smoke". Counsel drew my attention particularly to the passages at pages 26 and 27 dealing with prisons, mental health facilities,

and hospital grounds. He acknowledged that although the respondents referred to this document in their 2014 Policy, it asked NHS Boards, taking account of the outcome of *M* (then depending) to ensure that indoor mental health facilities were smoke-free by 2015. The reference to *M* is odd, because the petitioner in that case did not challenge the ban on smoking indoors. So far as smoke-free hospital grounds were concerned, the "action" was in the following terms:

> "All NHS Boards will implement and enforce smoke-free grounds by March 2015. Smoke-free status means the removal of any designated smoking areas in NHS Board buildings or grounds. We will work with Boards to raise awareness of the move to smoke-free hospital grounds. This action will not apply to mental health facilities."

Comprehensive Smoke Free Implementation Plan

[33] This document was produced by the Directorate of Forensic Mental Health and Learning Disabilities in August 2015 and is directed specifically to the situation at Rowanbank and Leverndale. It includes information that 60% of the relevant population of 124 in-patients smoked regularly. Patients required to be supervised on smoke breaks, and the time spent by staff on such supervision was estimated to be around two hours each day.

[34] In addition to a list of issues which affect patients, staff, carers and visitors, in very similar terms to those mentioned in the other documents, it mentions the reinvestment of time spent supervising smoking in therapeutic work which could contribute to patients' care, treatment and recovery.

Article 8 – Decision

[35] The respondents identify the legitimate aim that they seek to achieve as the protection of the health of patients who are smokers, patients who are non-smokers and the

health of the respondents' staff who have to engage with patients who smoke. I have no difficulty, given the adverse effects of smoking on smokers and those exposed to smoke, in accepting, as did the Supreme Court in *M*, that the aim is a legitimate objective for the purposes of Article 8. It is one sufficiently important to justify a limitation on the rights protected under it. There is plainly a rational connection between the ban and that legitimate objective: *M*, paragraph 59.

[36] The question is whether the respondents have demonstrated that the prohibition is proportionate. I have to consider whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective, and whether a fair balance has been struck between the rights of the individual and the interests of the community having regard to the severity of the impact of the measure on the individual's rights and the contribution of the measure to the achievement of the objective.

[37] I do not accept Mr Leighton's submissions that it would be open to the court to identify the alternative measure which was least intrusive, and that to do so would be a simple task in the present case. I do not consider that it would be legitimate for me to attempt the exercise. The extent of the margin of discretion, or the intensity of review, will in every case be dependent on the context of the decision. I see no proper basis in law, however, for my embarking on the task of trying to identify, as Mr Leighton asked me to, the appropriate less intrusive alternative measure. In the course of submissions I heard about a variety of measures that might be taken, short of a comprehensive ban, involving allowing smoking at particular locations, or at particular times. The ways in which partial bans might operate are myriad, and the court is not equipped to select a particular measure as being the least intrusive. I am approaching the matter in the way set out by Lord Reed in *Christian Institute* in the passages already referred to.

[38] I turn to the submissions made about the course taken by the executive and the legislature in relation to the legislation regulating the smoking of tobacco, and about statements made by ministers in this context. The petitioners were not referring to the materials in question with a view to construing legislation. *Pepper* v *Hart* [1993] AC 593, therefore, does not apply. Nor was the exercise one of the sort contemplated in *Wilson* – the statements were not being prayed in aid in determining whether or not legislation was compatible with a Convention right. Rather the aim was to demonstrate that the executive appeared to be pursuing one course, and that the respondents, a different public authority, were pursuing a different and contradictory one. That indicated, counsel submitted, that the course chosen by the respondents was a disproportionate interference with the petitioners' Article 8 rights. In this context I understood the materials to be relied upon as representing statements of policy, and of a policy at odds with that adopted by the respondents. It should be borne in mind that health boards exist to perform certain of the duties imposed by statute on the Scottish Ministers. In that context I did not regard reference to the materials as in principle inadmissible. The same point could in any event be made by reference to the legislation actually passed.

[39] A similar point emerges from the material relied on by the respondents – it is apparent that the respondents have done more than was required of them in the 2013 policy. The answer given by the minister in 2015 is not at odds with the expectation expressed in the 2013 policy.

[40] All of the materials referred to by Mr Leighton were produced in the context of the passage of the 2005 Act and the 2016 Act. Both Acts create offences of smoking, and permitting someone to smoke, in particular places. Section 4(2) of the 2005 Act makes provision for regulations prescribing premises as "no-smoking premises", and section 4(3)

provides for regulations prescribing premises, parts of premises or classes of premises to be excluded from the definition of "no-smoking premises". The Prohibition of Smoking in Certain Premises (Scotland) Regulations 2006 were made, and prescribed psychiatric units as no smoking premises. Designated rooms in psychiatric hospitals were exempted. Section 20 of the 2016 Act inserts into the 2005 Act new sections 4A to 4D. Sections 4A and 4B create offences of smoking outside hospital buildings and of permitting others to smoke outside hospital buildings. Section 4D(4) empowers the Scottish Ministers by regulations to exempt hospitals and parts of hospitals from the effect of sections 4A and 4B.

[41] Mr Campbell did not dispute that the intention of the Scottish Parliament was to provide a power to exempt premises such as the grounds of psychiatric hospitals from the provisions rendering it an offence to smoke outside hospital buildings.

[42] The material dating from 2005 is irrelevant. Matters have moved on very significantly since then. It is surprising that the petitioner referred to it at all, given the decision of the Inner House on the point, and that the argument was not pursued in the Supreme Court.

[43] I do not regard the minister's answer on 6 October 2015 as a statement of a policy that mental health patients should be allowed to smoke on hospital grounds. Her answer may have reflected her understanding of what would happen in practice. Particular care requires to be taken in relation to answers given to questions for the reasons expressed in *Wilson* by Lord Nicholls of Birkenhead at paragraph 67.

[44] The real question seems to me to be one about the relevance or otherwise, in assessing the proportionality of the respondents' measure, of the circumstances that the respondents have moved further and faster in implementing a comprehensive ban on smoking in mental health hospitals than the executive required of them in 2013, and that the

Scottish Parliament has continued to make provision for regulations to exempt premises from provisions which would otherwise mean that it was an offence to smoke in a particular place or to permit another person to do so.

[45] So far as the 2005 Act and the 2016 Act are concerned, the considerations relevant to the creation of an offence are not identical to those relevant to the imposition of a prohibition by means of policy and without a penal consequence. Mr Leighton, rightly, did not ask me to construe the exemption in the 2016 Act by reference to the minister's answer given on 6 October 2015. Whatever the minister's understanding in October 2015 of what might occur in practice at a psychiatric hospital, the result in the legislation is simply that there is provision under which an exemption may be given by regulations for such hospitals in relation to the provisions creating offences. There is nothing inherently inconsistent in having, on the one hand, legislation that makes provision for exemption by way of regulations from penal provisions with regard to smoking in the grounds of hospitals and, on the other, action on the part of a health board that seeks by administrative action to prohibit smoking in grounds that may be exempt under the legislation.

[46] The direction of travel, generally, of the executive and the respondents was the same. The aspiration of the executive as expressed in the ministerial foreword to the 2013 policy was "a tobacco-free Scotland". The goal was defined as a smoking prevalence of 5% or less of the adult population by 2034. What can certainly be said is that the respondents have moved more swiftly and to more comprehensive effect than indicated in the "action" required of them in that policy document. The executive did not require that smoking on the grounds of mental health hospitals be brought to an end by the same date set for other hospitals. There is, however, nothing in any of the materials to which I have been referred by either party indicating that there was a policy on the part of the executive to prohibit or

otherwise preclude health boards from exceeding the target imposed in the 2013 policy. I do not detect any positive intention on the part of the executive that the practice of smoking in the grounds of psychiatric hospitals should continue for any particular period. What the 2013 policy does clearly indicate is a recognition that health boards should not be required to eradicate the practice by March 2015.

[47] Although the 2016 Act and related materials were, obviously, not before the Inner House when it considered the policy behind the 2005 Act, very similar considerations apply to the policy behind the 2016 Act, and I see no reason to differ from the conclusion expressed at paragraph 76 of the Opinion of the court, in *M*, reported at 2015 SC 112:

> "The fact that it was and is deemed prudent not to force the issue, by criminalising smoking in the open air, does not mean that the policy approved of that practice."

[48] There is no merit in the proposition that the decision of the respondents was contrary to government policy.

[49] The documents to which I was referred by the respondents, and from which I have quoted, set out a variety of matters supporting the proposition that cessation of smoking by patients would bring benefit for patients and staff. They highlight, amongst others, the following considerations.

- The health of staff
- The health of patients who are not smokers
- The health of patients who are smokers
- The health of visitors
- Mental health patients are more likely to smoke, to be more nicotine dependent, to smoke for longer, and to smoke more heavily than the general population

- Mental health patients experience poor physical health, to which smoking contributes
- Mental health patients have a reduced life expectancy.
- The risk of death from smoking significantly exceeds that from suicide in mental health patients.
- Evidence that smoking cessation was associated with improved mental health.
- Evidence that smoking is harmful to mental health.
- That treating mental health patients differently from other patients may contribute to the stigmatisation of mental health conditions and to the perception that people with mental health conditions are "different".
- Medical costs.
- Patients' own finances.
- The desirability of continuing to provide a smoke-free environment for patients progressing from the State Hospital to conditions of lower security.

[50] That smoking by patients impacts on the work of staff, as well as their working environment, was highlighted in the 2011 guidance. Cessation of smoking was said to provide staff with the opportunity to work with service users in ways which do not revolve around the negotiation of smoking rights. Time otherwise spent in such negotiation would by implication become available for other purposes. There is reference to the demands on staff to escort service users to and from shelters. That point is further explained, but not in my view introduced, in the 2015 Implementation Plan, where there is mention of the time actually spent on supervising smoking, and the use to which such time might otherwise be put in the care and treatment of the patients.

[51] It is apparent from Dr de Caestecker's affidavit that a particular area of concern was the protection of the health of staff, and their right not to be exposed to tobacco smoke. It was not disputed that staff would be exposed to tobacco smoke from patients smoking in the grounds of Rowanbank or Leverndale, or that patients would require to be supervised by staff during smoking breaks.

[52] The respondents started from a position of treating mental health patients differently from other patients. That mental health patients might require different measures from other patients in relation to smoking was something in the mind of the respondents, and was reflected in the exemption initially made for mental health hospitals so far as smoking in hospital grounds was concerned. It is perhaps not surprising that the respondents proceeded in this way. As the Supreme Court recognised in *M*, there is a need to protect the residual autonomy of a person who has been subjected to therapeutic detention by requiring further intrusion, in this instance in the form of a measure preventing him from smoking, to be justified. Respect for that residual autonomy is the backdrop for the initial difference in treatment between mental health patients and other patients. Mr Leighton correctly emphasised that the right to make bad choices is an aspect of an individual's autonomy.

[53] It is true that what may be proportionate in one institution will not necessarily be proportionate in another, and that particular considerations relevant to security were taken into account in *M*. It does not, however, follow that, absent precisely the same circumstances as those obtaining in *M*, a prohibition on smoking in the grounds of a psychiatric hospital will be unlawful.

[54] In June 2014 the respondents embarked on what is in my view an informed and considered departure from their previous position. They considered, in particular, the right of patients to smoke, and the right of staff not to be exposed to smoke. Dr de Caestecker's

affidavit, at paragraph 25, refers to several meetings in which the respondents weighed those two competing rights up against each other.

[55] I am not reviewing the decision-making process of the respondents, but am considering, using the structured approach required for assessment of proportionality, whether the comprehensive prohibition on smoking was proportionate. It is, however, sometimes easier to reach the view that a measure was proportionate, and therefore lawful, in circumstances where the decision maker has, as in this case, carried out a balancing exercise itself. The respondents are a health board. I have already reflected on their statutory origin and functions. They are, in the context of a prohibition on smoking, a decision-maker with expertise in the subject-matter of the decision.

[56] I consider that it was within the margin of discretion open to the respondents to impose a comprehensive ban on smoking in the mental health hospitals for which they have responsibility. A partial ban on smoking would not protect patients or staff from the adverse effects of smoking as effectively as would a complete ban. The need to protect them arises against a background of duties of care to staff, and the understanding that mental health patients experience physical health which is poor relative to that of the population generally, and that they have a reduced life expectancy. The materials to which the respondents referred in the 2014 policy, and in particular the 2011 guidance at pages 16 and 18 to 19, which I have quoted above, identify particular problems associated with partial, as opposed to comprehensive, prohibitions and with introducing exceptions to comprehensive policies. They support the proposition that incomplete prohibitions are less effective in achieving the aim than are complete prohibitions. The serious nature of the adverse effects of smoking and exposure to second-hand smoke are such that I am satisfied that the impact of the prohibition is not disproportionate to its likely benefit.

Failure to Give Reasons

[57] This ground of challenge arises only in Mr A's case, as Lord Burns refused permission to proceed on this ground in Mr B's case.

[58] Mr Leighton submitted, under reference to *R* v *Secretary of State for the Home Department ex p Doody* [1994] 1 AC 531, at p560D-G, that fairness required in the present cases that reasons be given for a decision which impacted on the lives of the petitioners and other detained patients. He said that it was far from clear to what extent the 2014 policy reflected what was in the minds of the respondents when they decided to impose the prohibition. He said it was "not apparent" that it was available to patients such as Mr A, who have no access to the internet, although he did not positively assert that it was not available. The prohibition was insufficiently reasoned and fell to be reduced.

[59] There was little discussion in the debate before me as to whether the circumstances in which these decisions were taken was such as to trigger the common law duty to give reasons as a necessary aspect of fairness. Since I heard submissions, the Supreme Court has issued its judgment in *Dover District Council* v *CPRE Kent* [2017] UKSC 79. Part of the judgment concerns the common law duty to give reasons in the context of planning law. Although that is the context, and while the court does not depart from the notion that there is no general duty to give reasons for administrative decisions, it decided that there was a common law duty to give reasons, in the particular circumstances, notwithstanding that a previous statutory duty to give reasons had been removed. I therefore anticipate that the case will come to be cited and discussed in administrative law contexts other than planning law. Against that background I considered whether I should seek further submissions from parties as to any relevance that *Dover DC* might have to this chapter of the petitioners'

submissions. I decided that I did not require to do so, as I am able to deal with the point by proceeding on the hypothesis, which favours the petitioners, that the decision in this case was one for which reasons required to be given. For the following reasons I consider that if there was such a duty, the respondents fulfilled it.

[60] I consider that it is clear from the terms of the 2014 policy that the respondents decided upon a comprehensive ban on smoking with a view to protecting the health of patients, staff, visitors and contractors, and that they had taken into account research evidence about the effect of smoking on mental health. The 2014 policy refers to the 2013 policy and the 2011 guidance. The considerations set out in those latter documents provide further information about the considerations which favoured a comprehensive prohibition and which were in the minds of the respondents when they made the decision. An informed reader of these three documents would not be left in real or substantial doubt as to what the reasons for it were and what were the material considerations which were taken into account in reaching it: *Wordie Property Co Ltd* v *Secretary of State for Scotland* 1984 SLT 345, Lord President (Emslie) at page 348.

[61] I am not asked to adjudicate on the mechanisms by which these documents should be made available to detained patients such as Mr A. Mr Leighton raised a question as to whether they were accessible only on the internet, and therefore difficult for the petitioners to access. Mr Campbell submitted that his understanding was that paper copies were available and that access was not simply by way of the internet.

The Equality Act 2010

[62] Mr Leighton advanced two lines of argument. The first was that the comprehensive prohibition on smoking was direct and indirect discrimination contrary to sections 15 and 19

of the 2010 Act, and the second that the respondents had failed to carry out their duties under section 149 of that Act, and regulation 5 of the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 ("the 2012 regulations").

[63] There was no dispute that both petitioners had the protected characteristic of disability, by reason of their mental disorders. The submission in relation to section 15 was that the petitioners desired to smoke and were not permitted to do so. They were not permitted to do so because of their detention, which arose by reason of their disability. The submission in relation to section 19 was that the effect of the policy was disproportionately to prohibit smoking among persons who share the protected characteristic of disability compared with persons who do not share that characteristic. It was a practice that put persons with disabilities at a disadvantage when compared with persons without disabilities. That was because persons without disabilities could leave hospital and smoke, whereas detained patients, who had disabilities, could not.

[64] Mr Leighton recognised that on the assumption that the foregoing analysis was sound and that it demonstrated, *prima facie*, discrimination contrary to section 15 or section 19, there would be a defence if the respondents could show that it was a proportionate means of achieving a legitimate aim. He submitted that the result of a claim under section 15 or section 19 will not necessarily be identical to one under Article 8 read with Article 14 ECHR. He did, however, recognise that it was difficult, in the present case, to find any basis on which it would be open to me to reach a different conclusion in relation to these claims from that reached by the Supreme Court in relation to the Article 8 and 14 claim at paragraph 65 of *M*. I agree. The petitioners have not made out claims under section 15 or 19.

[65] In relation to section 149 of the 2010 Act and regulation 5 of the 2012 regulations he submitted that the respondents had not had due regard to the needs set out in section 149(1)(a), (b) and (c), and that they had not carried out an assessment of the sort, and in the way, desiderated in regulation 5.

[66] Section 149 so far as relevant for present purposes provides:

> (1) A public authority must, in the exercise of its functions, have due regard to the need to –
>
> (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
>
> (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
>
> (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
>
> …
>
> (3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to —
>
> (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
>
> (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

(c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

(4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

(5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to —

(a) tackle prejudice, and

(b) promote understanding.

[67] Regulation 5 provides:

"(1) A listed authority must, where and to the extent necessary to fulfil the equality duty, assess the impact of applying a proposed new or revised policy or practice against the needs mentioned in section 149(1) of the Act.

(2) In making the assessment, a listed authority must consider relevant evidence relating to persons who share a relevant protected characteristic (including any received from those persons).

(3) A listed authority must, in developing a policy or practice, take account of the results of any assessment made by it under paragraph (1) in respect of that policy or practice.

(4) A listed authority must publish, within a reasonable period, the results of any assessment made by it under paragraph (1) in respect of a policy or practice that it decides to apply.

(5) A listed authority must make such arrangements as it considers appropriate to review and, where necessary, revise any policy or practice that it applies in the exercise of its functions to ensure that, in exercising those functions, it complies with the equality duty.

(6) For the purposes of this regulation, any consideration by a listed authority as to whether or not it is necessary to assess the impact of applying a proposed

> new or revised policy or practice under paragraph (1) is not to be treated as an assessment of its impact."

[68] He referred to the judgment of McCombe LJ in *Bracking* v *Secretary of State for Work and Pensions* [2013] EWCA Civ 1345, at paragraphs 26, 60 and 61. He was particularly critical of the decision making process as it is described in paragraph 18 of Dr de Caestecker's affidavit, where absence of response was taken to signify the assent of recipients to the proposed changes to the policy. That did not demonstrate that the duty had been exercised in substance, with rigour and with an open mind.

[69] Mr Campbell recognised that there was no single document containing an assessment of the impact of the comprehensive prohibition on smoking against the needs mentioned in section 149(1). Impact assessments were produced, but they related to smoking cessation services, and he rightly conceded that they were of no assistance to the respondents in answering this chapter of the petitioners' submissions. He submitted that the duty laid on the respondents was not a duty to achieve a result, but a duty to have due regard to the needs set out in section 149(1). Due regard is that which is appropriate under all the circumstances: *R(Baker and others)* v *Secretary of State for Communities and Local Government* 2009 PTSR 809, Dyson LJ at paragraphs 30 to 31. The decision making process needed to be looked at as a whole: *Watt, petitioner* [2015] CSOH 117.

[70] I agree with McCombe LJ's characterisation in *Bracking* at paragraph 27 of the following, which he sets out at paragraph 26, as uncontroversial principles:

> "(1) As stated by Arden LJ in *R (Elias)* v *Secretary of State for Defence* [2006] 1 WLR 3213; [2006] EWCA Civ 1293 at [274], equality duties are an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation.
>
> (2) An important evidential element in the demonstration of the discharge of the duty is the recording of the steps taken by the decision maker in seeking to meet the statutory requirements: *R (BAPIO Action Ltd)* v *Secretary of State for*

the Home Department [2007] EWHC 199 (QB) (Stanley Burnton J (as he then was)).

(3) The relevant duty is upon the Minister or other decision maker personally. What matters is what he or she took into account and what he or she knew. Thus, the Minister or decision maker cannot be taken to know what his or her officials know or what may have been in the minds of officials in proffering their advice: *R (National Association of Health Stores)* v *Department of Health* [2005] EWCA Civ 154 at [26 – 27] per Sedley LJ.

(4) A Minister must assess the risk and extent of any adverse impact and the ways in which such risk may be eliminated before the adoption of a proposed policy and not merely as a 'rearguard action', following a concluded decision: per Moses LJ, sitting as a Judge of the Administrative Court, in *Kaur & Shah* v *LB Ealing* [2008] EWHC 2062 (Admin) at [23 – 24].

(5) These and other points were reviewed by Aikens LJ, giving the judgment of the Divisional Court, in *R (Brown)* v *Secretary of State for Work and Pensions* [2008] EWHC 3158 (Admin), as follows:

i) The public authority decision maker must be aware of the duty to have 'due regard' to the relevant matters;

ii) The duty must be fulfilled before and at the time when a particular policy is being considered;

iii) The duty must be 'exercised in substance, with rigour, and with an open mind'. It is not a question of 'ticking boxes'; while there is no duty to make express reference to the regard paid to the relevant duty, reference to it and to the relevant criteria reduces the scope for argument;

iv) The duty is non-delegable; and

v) Is a continuing one.

vi) It is good practice for a decision maker to keep records demonstrating consideration of the duty.

(6) "[G]eneral regard to issues of equality is not the same as having specific regard, by way of conscious approach to the statutory criteria." (per Davis J (as he then was) in *R (Meany)* v *Harlow DC* [2009] EWHC 559 (Admin) at [84], approved in this court in *R (Bailey)* v *Brent LBC* [2011] EWCA Civ 1586 at [74-75].)

(7) Officials reporting to or advising Ministers/other public authority decision makers, on matters material to the discharge of the duty, must not merely tell

the Minister/decision maker what he/she wants to hear but they have to be 'rigorous in both enquiring and reporting to them'*: R (Domb)* v *Hammersmith & Fulham LBC* [2009] EWCA Civ 941 at [79] per Sedley LJ.

(8) Finally, and with respect, it is I think, helpful to recall passages from the judgment of my Lord, Elias LJ, in *R (Hurley & Moore)* v *Secretary of State for Business, Innovation and Skills* [2012] EWHC 201 (Admin) (Divisional Court) as follows:

(i) At paragraphs [77-78]

"[77] Contrary to a submission advanced by Ms Mountfield, I do not accept that this means that it is for the court to determine whether appropriate weight has been given to the duty. Provided the court is satisfied that there has been a rigorous consideration of the duty, so that there is a proper appreciation of the potential impact of the decision on equality objectives and the desirability of promoting them, then as Dyson LJ in Baker (para [34]) made clear, it is for the decision maker to decide how much weight should be given to the various factors informing the decision.

[78] The concept of 'due regard' requires the court to ensure that there has been a proper and conscientious focus on the statutory criteria, but if that is done, the court cannot interfere with the decision simply because it would have given greater weight to the equality implications of the decision than did the decision maker. In short, the decision maker must be clear precisely what the equality implications are when he puts them in the balance, and he must recognise the desirability of achieving them, but ultimately it is for him to decide what weight they should be given in the light of all relevant factors. If Ms Mountfield's submissions on this point were correct, it would allow unelected judges to review on substantive merits grounds almost all aspects of public decision making."

(ii) At paragraphs [89-90]

"[89] It is also alleged that the PSED in this case involves a duty of inquiry. The submission is that the combination of the principles in *Secretary of State for Education and Science* v *Tameside Metropolitan Borough Council* [1977] AC 1014 and the duty of due regard under the statute requires public authorities to be properly informed before taking a decision. If the relevant material is not available, there will be a duty to acquire it and this will frequently mean than some further consultation with appropriate groups is required. Ms Mountfield referred to the following passage from the judgment of Aikens LJ in *Brown* (para [85]):

> '….the public authority concerned will, in our view, have to have due regard to the need to take steps to gather relevant information in order that it can properly take steps to take into account disabled persons' disabilities in the context of the particular function under consideration.'
>
> [90] I respectfully agree……"

[71] The duty imposed by regulation 5(1) is to assess impact "where and to the extent necessary to fulfil the equality duty". It was not suggested in submission that a failure to comply with regulation 5 of the 2012 regulations would of itself result in reduction of a decision if the duties in section 149 had been complied with in substance. Rather, the submission for the petitioners was, as I understood it, that the absence of an assessment obviously meeting the requirements of regulation 5 evidenced a lack of regard for those duties. Neither party's submissions focused on the question of whether making an impact assessment was necessary in the circumstances of this case or to what extent it might have been necessary.

[72] As I have already said, under reference to the submissions about Article 8 ECHR, the respondents' decision to impose a comprehensive prohibition represented a change from a position whereby they treated patients in mental health hospitals and units differently from other patients. They proceeded initially on the basis that persons with disabilities by reason of mental disorder should be treated differently from other patients. They came to depart from that view.

[73] Dr de Caestecker's affidavit contains several references to the consideration of the needs to eliminate discrimination, tackle prejudice, and remove or minimise health disadvantage experienced by persons with disabilities by reason of mental disorder. At paragraph 17 she refers to the view that the exemption should be removed "on the basis of equality". At paragraph 23 she refers to the concern about continuing to expose mental

health patients and those caring for them to tobacco smoke, where other patients and staff were not so exposed. At paragraph 24 there is reference to concern that the exemption from the smoke-free policy would contribute to the stigma of mental health patients. In the same passage Dr de Caestecker refers to consideration of communications from a third sector organisation outlining concerns about removing the exemption.

[74] The respondents consulted with smokers in Leverndale and Rowanbank in 2013, and there was a more limited consultation in 2015.

[75] Although there is no single document reflecting an assessment of impact, the documents referred to in the 2014 policy also contain a number of relevant references. The 2011 guidance, in particular, includes statements that continuing to allow smoking in mental health hospitals perpetuates inequalities in the treatment of mental health problems and that allowing mental health patients to smoke stigmatises them as different. It refers to the death toll associated with smoking in mental health patients.

[76] It seems to me clear that the protected characteristic of disability, and in particular disability resulting from mental disorder, was considered when the decision was made to impose a comprehensive ban on smoking, and that due regard was had to the needs identified in section 149 of the 2010 Act. Although those needs were not the only consideration – the need to protect staff from second-hand smoke was clearly a very significant factor – I accept that they informed the decision and that due regard was had to them. They formed part of the reasons for taking the decision.

[77] The purpose of section 149 and regulation 5 is to ensure that considerations of equality are central to the formation of policy. In the circumstances of this case, I am satisfied, for much the same reasons as I set out in relation to the case under Article 8, that the respondents sought to balance considerations that had previously been thought to

favour exempting mental health patients from a comprehensive ban on smoking against a series of other considerations, which included an intention to reduce stigma associated with mental disorder and to remove discrimination in the provision of healthcare to people with mental disorder. The obligation under section 149(1) has in my view been complied with in substance.

Possession of Sources of Ignition

[78] Since the decision of the Supreme Court, patients both in Rowanbank and in Leverndale have been allowed to possess tobacco, but not sources of ignition. There appears to have been some confusion as to whether there was in at least one of those institutions, also a ban on possession of tobacco. While there was apparently some dispute as to whether that did or did not represent a change in position as regards Leverndale, the position in each hospital was the same at the date of the substantive hearing. The prohibition in each case is on possessing sources of ignition. I was satisfied that the permission granted by Lord Burns was apt to cover a challenge in Mr B's case to the prohibition in question.

[79] Section 286(1) of the 2003 Act provides:

> "(1) Regulations may authorise –
>
> (a) the search of such persons detained in hospital by virtue of this Act or the 1995 Act as may be specified in the regulations and of anything they have with them in the hospital in which they are detained;
>
> (b) the taking, from external parts of the body of those persons and, by means of swabbing, from the mouth of those persons, of samples of body tissue, blood or other body fluid or other material, the taking hypodermically from those persons of samples of blood and the examination of those samples;

(c) the placing of restrictions on the kinds of things which those persons may have with them in the hospitals in which they are detained and the removal from them of articles kept in breach of such restrictions;

(d) the placing of prohibitions and restrictions on the entry into and the conduct while in those hospitals of persons ('visitors') visiting those persons or otherwise entering or seeking to enter those hospitals and on the kinds of things which visitors may bring with them into those hospitals;

(e) the surveillance, whether directly or otherwise, of those persons and visitors;

(f) the search of visitors and of anything they bring with them into those hospitals, and make that which is authorised subject to conditions specified in the regulations."

[80] Regulations 2, 4, 5 and 8 of the 2005 regulations provide:

"2(1) For the purposes of section 286(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003, a person detained in hospital by virtue of that Act or the Criminal Procedure (Scotland) Act 1995 is a specified person if either of the conditions specified in paragraph (2) and both of the conditions in paragraphs (3) and (4) are met.

(2) The conditions specified in this paragraph are –

(a) the person is detained in—

(i) a state hospital;

(ii) the Orchard Clinic in Royal Edinburgh Hospital, Morningside Terrace, Edinburgh;

(iii) the Rowanbank Unit, 133C Balornock Road, Glasgow; or

(iv) the Medium Secure Service, Rohallion Clinic, Murray Royal Hospital, Muirhall Road, Perth; or

(b) it is less than 6 months starting with the date of recording since the person's responsible medical officer has recorded a reasoned opinion that the person has sought to acquire or is likely to seek to acquire, any item which is likely to be prejudicial to the health or safety of any person or to the security or good order of the hospital.

(3) The hospital managers have informed the person detained, unless to do so would, in the opinion of the patient's responsible medical officer, be prejudicial to the person's health or treatment, that person's named person and the Commission –

(a) that the person detained is to be a specified person; and

(b) where applicable to the person in question, the date of the recording of the opinion mentioned in paragraph (2)(b).

(4) The hospital managers have informed the person detained, unless to do so would, in the opinion of the patient's responsible medical officer, be prejudicial to the person's health or treatment, and that person's named person –

(a) that, subject to the conditions mentioned in regulation 4, specified persons are subject to the measures; and

(b) that a specified person has the right to the review mentioned in regulation 3 and the re-assessment mentioned in regulation 5(b).

…

4. Subject to the general conditions in regulation 5 and the particular conditions in regulations 6 to 11, the following measures are authorised –

(a) the search of specified persons and of anything they have with them in the hospital in which they are detained;

(b) the taking, from external parts of the body of those persons and, by means of swabbing, from the mouth of those persons, of samples of body tissue, blood or other body fluid or other material, the taking hypodermically from those persons of samples of blood and the examination of those samples;

(c) the placing of restrictions on the kinds of things which those persons may have with them in the hospitals in which they are detained and the removal from them of articles kept in breach of such restrictions;

(d) the placing of prohibitions and restrictions on the entry into and the conduct while in those hospitals of persons ("visitors") visiting those persons or otherwise entering or seeking to enter those hospitals and on the kinds of things which visitors may bring with them into those hospitals;

(e) the surveillance, whether directly or otherwise, of those persons and visitors;

(f) the search of visitors and of anything they bring with them into those hospitals.

5. The general conditions are that –

(a) the measures may only be applied in respect of any specified person where, in the opinion of that person's responsible medical officer, not to apply them would pose a significant risk to the health, safety or welfare of any person in the hospital or the security or good order of the hospital;

(b) the responsible medical officer shall, at the request of a specified person, or that person's visitor in any case where a measure is applied to that visitor, re-assess the risk mentioned in paragraph (a) and may as a result of such re-assessment reverse the decision to apply the measure to that person or that person's visitor or may have the measure applied in a different way;

(c) where a measure is applied to any specified person, the reasons for and the outcome of applying that measure shall be recorded in that person's medical records and a separate record shall be made by the managers of the hospital; and

(d) the specified person and that person's named person shall be given notice of the entry in the medical records unless, in the case of the specified person, to do so would, in the opinion of the specified person's responsible medical officer, be prejudicial to the specified person's health or treatment.

……

8(1) The placing of restrictions on having certain kinds of things in hospital and the removal of articles mentioned in regulation 4(c) are subject to the condition in paragraph (2).

(2) The condition is that restrictions shall be placed on having any article or class of article either generally or in terms of the number of, access to or use of such article or class of article so as to minimise the impact on the freedom of the specified person compatible with the general condition in regulation 5(a)."

[81] The decision of the Supreme Court in relation to the prohibition on possession of tobacco products is in the judgment of the court, delivered by Lord Hodge, at paragraphs 34 to 41:

"[34] The impugned decision involves not only a comprehensive ban on smoking, which extends to smoking in the grounds of the state hospital and on visits to a detained person's home, but also a policy of searching both detained patients and visitors for and confiscating tobacco. While the power to search for and confiscate tobacco is a necessary component of the decision as it is the

means by which the comprehensive ban can be enforced, I am not persuaded that the comprehensive ban itself falls within the scope of the 2003 Act. In my view the Board is correct in its submission that the comprehensive ban, viewed on its own, involves the exercise of a power of management under the 1978 Act. But, for the reasons which I set out below, I have come to the view that the supporting prohibition on possession of tobacco products and the power to search for and confiscate such products fall within the scope of the 2003 Act and the 2005 Regulations.

[35] First, I do not accept the submission that the 2003 Act is concerned only with the treatment of individual patients and that it does not impinge on more general management policies. That Act, which replaced the 1984 Act, provides, among other things, for the detention of and the giving of care and treatment to mental health patients. Many sections of the 2003 Act relate to the making of such provision to the individual patient. But the discharge of functions under the 2003 Act is not confined to individual care and treatment. In Part 18 of the Act (which is headed "Miscellaneous") there are a series of sections (sections 281–286) which provide either directly or through regulations for the withholding of correspondence and the regulation of the use of telephones, as well as for the functions with which this appeal is concerned, namely the placing of restrictions on the kinds of things which specified persons may have in a hospital, searches and confiscation. The regulations made in support of those provisions, namely the 2005 Regulations to which I have referred in paras 24 and 25 above and also the Mental Health (Definition of Specified Person: Correspondence) (Scotland) Regulations 2005 (SSI 2005/466) and the Mental Health (Use of Telephones) (Scotland) Regulations 2005 (SSI 2005/468), are subject to conditions (a) as a general rule that the detained patient, his or her named person and the Mental Welfare Commission for Scotland are informed that he or she is a specified person and (b) that the detained person is informed of the restriction. Thus interested parties must be informed of measures which affect individual patients, whether as a result of general management policies or of individual targeting of patients. The relevant regulations also require records to be kept of any decisions to search a specified person and to prohibit or restrict the use of telephones by such a person.

[36] While the further requirement in the 2005 Regulations (regulation 5(c)) to record a measure in an individual patient's medical records may seem unnecessary where a measure is of general application, that is not, in my view, a sufficient indication of an intention to confine section 286 and the 2005 Regulations to individually targeted measures. The requirements in each of the sets of regulations mentioned in paragraph 35 above are consistent with the policy underlying section 286 of the 2003 Act that the Scottish Government and the Mental Welfare Commission should monitor the terms of policies for such measures and their operation: paragraph 21 above. I can see no rationale for excluding measures of general application from this supervision, nor did counsel suggest any. I recognise that some of

the matters mentioned in section 1(3) of the 2003 Act are not relevant to the discharge of these functions, especially when the measures are not targeted at individual detained patients; but section 1(2) and (9) provide for that.

[37] Secondly, the 2005 Regulations do not set limits on the things, the possession of which may be prohibited or restricted, and for which specified persons or visitors may be searched. Both the heading of section 286 of the 2003 Act and the title of the 2005 Regulations refer to safety and security, but there is no provision in either the section or the 2005 Regulations which confines the things to items such as weapons which might threaten the safety of others. Section 286 also provides for the taking of samples from persons, including swabs and blood (subsection (1)(b)) and the surveillance of specified persons or visitors: (subsection (1)(e)).

[38] Thirdly, the focus of the section and the regulations made under it is on the regulation of activities which impinge on the autonomy of individuals. That focus on the detained patient's autonomy is consistent with the Millan report's emphasis on the need to respect human rights. It manifests itself in greater transparency by legislative provision for such policies, and through the informing of interested parties of the regulated measures, the maintenance of records of such measures, and the supervision by the Scottish Government and the Mental Welfare Commission.

[39] The devising of policies and the carrying out of such measures have thus become functions under the 2003 Act. The principles in section 1 of that Act apply to such measures in so far as they are relevant. One principle which is clearly relevant is the obligation in section 1(4) to discharge the function in the manner that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances — an obligation to which the Code of Practice draws attention.

[40] The Board did not purport to act under the 2003 Act in instituting the policy of prohibiting the possession of tobacco products, searching for such products and confiscating them. It may be the case that the consultation exercises which the Board carried out during 2011 were sufficient to comply with the obligations in section 1(2) and (3) of the 2003 Act. But there appears to have been no consideration of the obligation under section 1(4) nor compliance with the obligations to inform and record in the 2005 Regulations. This is not surprising as the Board considered that it was acting under the 1978 Act.

[41] As a result, the prohibition on having tobacco products and the related powers to search and confiscate are in my view illegal and fall to be annulled. …"

[82] Both petitioners contend that the reasoning of the Supreme Court regarding the prohibition on possession of tobacco products applies equally to the prohibition on possession of sources of ignition.

[83] The means by which the prohibition on sources of ignition had been achieved was not identical in each hospital. I was told that patients in Rowanbank had always been prohibited from possessing sources of ignition. There was no document produced in which that policy was recorded. The respondents, however, referred to a Scottish Executive Circular *NHS HDL (2006) 48*. It was produced at a time when the range of forensic psychiatric services was increasing in response to the need identified in the *Millan Report* and for which provision was made in the 2003 Act for a range of levels of secure services, including medium secure facilities. Annex B deals with medium secure care standards. Standard 7, at page 19 of Annex B, is entitled "Excluded items". It states:

> "**Standard 7.1 Statement:**
> Medium security forensic inpatient services will have in place appropriate physical and procedural security measures to manage the risk associated with the introduction of potentially harmful items of substances proportionate to the level of risk & the effect of the measures on patients, visitors & staff rights, and the effect on patients quality of life
>
> **Standard 7.2 Rationale:**
> Excluded items are excluded because their makeup or properties are hazardous. This may be because
>
> - they could be used to harm others;
> - could be used in attempts to escape
> - because of their harmful properties (such as drugs or alcohol); or
> - their intrinsic illegality such as child pornography or drugs
>
> As a number of patients within medium security units may have histories that include offending or exploitative behaviours, exclusions may include items used to trade & encourage criminality such as pornography. The potential for patients or carers to be coerced into bringing excluded items in, may also exist and should be addressed."

[84] Standard 8 in the same document, which relates to the control of restricted items, is in very similar terms, absent the reference to those the possession of which involves intrinsic criminality. It explains items may be restricted rather than excluded because they can be valuable tools in encouraging normalisation and resisting institutionalisation, providing diversionary, recreational, educational, social and rehabilitative value. It explains that in medium secure settings, patients will be preparing for safe transfer to conditions of lesser security, and therefore require controlled exposure to restricted items that may be freely available in the "destination setting".

[85] Mr Campbell submitted that the source of the prohibition in Rowanbank was to be found in that document. There was no document produced which specifically recorded the prohibition within Rowanbank on possessing sources of ignition. There was no document equivalent to the Circular relative to Leverndale.

[86] Mr Leighton drew to my attention the terms of paragraph 3.2:3 "Restriction on Patients Belongings" in *Specified Persons Policy and Procedure*, a document prepared by the respondents. It reads:

> "Certain items are commonly prohibited and do not require to be made restricted items nor do patients require to be specified unless searching is required in relation to those items.
>
> Each ward/unit may have other items on a prohibited list which in other settings may be restricted or not. It is acceptable for lists of restricted items to differ providing the list is proportionate (not unnecessarily extensive) for the safety, security and therapeutic environment of the ward/unit. Common items that would be prohibited in a ward environment without specific restriction on each patient would include.
>
> - Knifes [*sic*], swords including replicas
> - Drugs legal / illegal prescription and non prescription
> - Explosives
> - Firearms including replicas
> - Flammable liquids and gels

> Each ward / unit may have a list of restricted items which can vary depending on the security setting. Again these should not required [*sic*] specific measures to be in place unless searching of the patient is required. Below are examples of restricted items.
>
> - Lighters and matches
> - Wifi enabled equipment
> - Glass bottles
> - Pornography
> - Age restricted items such as films and computer games"

[87] The respondents' position is that the prohibition on the possession of sources of ignition is something that they have imposed by way of policy. Their position is reflected at page 2 of *Directorate of Forensic Mental Health and Learning Disabilities: Comprehensive Smoke Free Implementation Plan*, dated August 2015, which reads:

> "At present, patients can smoke cigarettes within the enclosed courtyards at Rowanbank Clinic, Campsie Ward, Bute Ward and Wards 5 & 6 at Leverndale within the designated smoking times and designated smoking areas within Leverndale Hospital site. Due to the nature of secure care, patients have no access to personal lighters within the ward environment, and require to be supervised at each smoke break. …"

[88] What is plain from the documents produced and the submissions of counsel is that the respondents have proceeded on the basis that it was open to them, as a matter of law, to prohibit the possession of certain types of items by detained patients without the need to use the specified persons procedure under the 2005 regulations. That has been the position in relation to sources of ignition, but also, as will be apparent from the documents quoted above, in relation to many other sorts of items as well. Possession of some of the items detailed in the *Specified Persons Policy and Procedure* document and *Circular NHS HDL (2006) 48* such as drugs and firearms is prohibited by the law applicable to the whole population. Others of the items, however, such as alcohol, pornography, glass bottles, flammable gels, and lighters and matches, are not subject to any such general prohibition. The respondents' understanding of the law appears to have been that it remained open to them,

notwithstanding the terms of the 2003 Act and 2005 regulations, to continue to impose prohibitions and restrictions by means of policy under their general powers of management, without reference to the 2005 regulations, and, indeed, in relation to detained patients who were not specified persons.

[89] The respondents have understood the law to be that while they required to use the procedures under the 2005 regulations if they were to search patients, they did not need to use those procedures simply to prohibit the possession of particular articles or substances.

[90] I was told that prohibitions imposed by the respondents by way of policy apply in settings other than psychiatric settings. Alcohol, for example, is prohibited on all the respondents' wards, whether providing medical or psychiatric care.

[91] Given the language used by the Supreme Court, there is no room for doubt that the court regarded the general prohibition on the possession of tobacco as being a restriction of the sort contemplated by section 286(1)(c), and one which was not lawful without the use of the procedures relative to specified persons. I cannot see any basis for distinguishing a prohibition on the possession of sources of ignition from the prohibition on possessing tobacco considered in *M*. Mr Campbell did not suggest that I could distinguish *M* in dealing with Mr A's case.

[92] He did attempt to distinguish *M* in Mr B's case. He sought to persuade me that the Supreme Court was concerning itself only with detained patients who were already specified persons by reason of their detention in high or medium secure hospitals, as the appellant in *M* was by dint of his detention in the State Hospital. Mr A, likewise, being detained in Rowanbank, is a specified person by virtue of regulation 2(2)(a)(iii) of the 2005 regulations. Mr B, however, is not "automatically" a specified person, and he has not become a specified person by virtue of any decision by his RMO under regulation 2(2)(b).

[93] Mr Campbell argued that considerable difficulties would arise if, in order to prohibit a detained patient from possessing an item, it was necessary in every case to make him a specified person on the basis of a reasoned opinion of his RMO under regulation 2(2)(b). Most detained patients are not accommodated in high or medium secure facilities, and will only become specified persons by virtue of a decision of the RMO under that regulation. It must therefore follow that section 286 of the 2003 Act does not contain the only management powers in relation to general controls on possession, since it cannot be correct that only specified persons are subject to controls on possession of items such as tobacco, and related products, such as sources of ignition.

[94] If it is unlawful to prohibit the possession of an item by a detained patient without using the procedures in the 2005 regulations, that would mean that in order to impose on any detained patient a prohibition against possessing an item (even an item in respect of which there was a general prohibition), that patient would have to be made a specified person by the RMO, and all decisions taken in accordance with the 2005 regulations. The result would be that any detained patient required to be a specified person, and the processes in the 2005 regulations followed, before staff could lawfully confiscate alcohol where the patient was visibly in possession of it on the ward. That would be a perverse result, and I should be slow to interpret the statute and the regulations in a way which would produce such a result.

[95] Some wards will have a mix of voluntary and detained patients. On a ward of that type, it might be that voluntary patients could lawfully be prohibited from having an item by virtue of a management decision to create a policy prohibiting it. On the same ward, detained patients could not be prevented from possessing the same item, unless there was a reasoned opinion of the sort desiderated in regulation 2(2)(b). This would be a

counterintuitive result, particularly given the nature of the statutory criteria which require to be satisfied before the imposition of either a compulsion order or a compulsory treatment order authorising detention. Neither type of order can be imposed unless there would be a significant risk to the health, safety or welfare of the patient or to the safety of some other person, if the patient were not provided with medical treatment to prevent his disorder worsening or to alleviate any of its symptoms or effects: section 64(5) of the 2003 Act, and section 57A(3) of the Criminal Procedure (Scotland) Act 1995. Neither order can lawfully remain in force unless the criteria continue to be satisfied, save in the case of patients subject to both a restriction order and a compulsion order. In relation to a patient subject to a restriction order, a compulsion order must remain in force if, as a result of the patient's mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, regardless of whether or not medical treatment is available: section 193(2) of the 2003 Act.

[96] Mr Leighton submitted that the results identified by Mr Campbell were not counterintuitive. On the contrary, the Scottish Parliament had determined to achieve a situation whereby no prohibitions whatsoever should be put on the possession of any item by a detained person other than in accordance with section 286(1) and the 2005 regulations, in recognition of the circumstance that their liberty has been removed, with a concomitant need for any further restriction on their autonomy to be made under statutory processes with all the protections built in to those.

[97] I do not suggest that the respondents' submissions regarding the practical consequences flowing from the decision of the Supreme Court are incorrect. I cannot however read, as they ask me to, that decision as being confined in its effect to patients who are already specified persons. There is no such restriction in the language used by Lord

Hodge. Indeed, what underlies the decision of the Supreme Court is the view that what the Scottish Parliament intended, in enacting the 2003 Act and the 2005 regulations, was to provide a regime for the regulation of the possession of items by detained patients, including the imposition of generalised prohibitions. Lord Hodge uses the expressions "detained patient" or "detained person", rather than "specified person" on a number of occasions. The passages at paragraphs 36 and 38 are particularly significant. The policy underlying section 286 is that policies for measures of the type it details should be monitored by Scottish Government and the Mental Welfare Commission. The rationale is the focus on the autonomy of the detained patient and the need for regulation of measures which impinge on that autonomy.

[98] What the respondents suggest in Mr B's case is that no authority under section 286 and the 2005 regulations is required for prohibitions affecting detained patients who are not specified persons. The necessity that a detained patient be a specified person, whether by virtue of where he is accommodated or by virtue of a decision of his RMO, before certain measures can be adopted in relation to him is itself one of the protections in the 2005 regulations. What section 286(1) authorises is the taking of measures in relation to "such persons detained in hospital … as may be specified in the regulations". The measures are, therefore, authorised only in relation to detained patients if they are also specified persons. For all these reasons I find it impossible to read the decision of the Supreme Court as rendering unlawful only the ban on possession of tobacco by detained patients who are specified persons. The basis of the decision is that in order for a ban on possession of tobacco to be lawful, it must be achieved by using the statutory procedures. That means that a measure prohibiting possession of an item will be lawful only in relation to a specified person, and then only if the other requirements of the regulations are complied with.

[99] In the light of the conclusion I have reached in relation to section 286 and the 2005 regulations, I have not considered separately whether the respondents complied with duties under section 1 of the 2003 Act with respect to the prohibition on possessing sources of ignition. It is fair to say that that issue was not the principal focus of submissions.

[100] It follows that I am bound to find that the prohibitions on the possession of sources of ignition are unlawful. They are unlawful because the respondents have sought to achieve those prohibitions without using the procedures under the 2005 regulations. It follows that they are not in accordance with domestic law, and for that reason are in breach of Article 8 ECHR.

[101] I recognise that this has not been the understanding upon which the respondents have been proceeding to date. The effect of the decision of the Supreme Court is potentially wide-ranging and may mean that the respondents cannot achieve what they have hitherto regarded as routine prohibitions on the possession of certain types of items, so far as detained patients are concerned, without using the specified persons procedures.

[102] Had I not been bound by the decision of the Supreme Court, I should have been interested to hear further discussion in relation to the following matters which occur to me as potentially meriting exploration regarding the construction of section 286(1) of the 2003 Act and the 2005 regulations.

[103] Section 286(1)(c) refers only to the placing of restrictions on the kinds of things which detained patients may have with them in hospital. In contrast to section 286(1)(d), it makes no reference to prohibitions. Similar distinctions are made in the related parts of the 2005 regulations. I note also that the Mental Health (Use of Telephones) (Scotland) Regulations 2005 (SSI 2005/468) distinguish between prohibitions and restrictions The differing use of language might suggest that the legislature had in mind a distinction

between restriction and prohibition. There may be a question as to whether that distinction was intended to allow for a situation whereby some items would be generally prohibited, but others would be subject to particular restriction. There might be logic in recognising that some types of items would always require to be prohibited in particular settings, but that greater rigour would be required in determining whether access to other types of items should be restricted. It might be that the legislature had in mind the practical difficulties that would arise if the specified person procedure required to be invoked in order to make every detained patient subject to a prohibition on, for example, the possession of alcohol in hospital. On the other hand, it may be that the language used reflects an understanding that where possession of items is concerned, a distinction between restriction and prohibition will not be productive of clarity.

[104] There was some discussion before me of the notion that section 286 and the associated regulations might not occupy fully the territory in relation to regulating the possession of items and their confiscation. It might be strange if staff had no other power to remove an item other than that provided in section 286(1)(c) and the regulations. Situations of emergency might arise whereby an item required to be removed immediately from a detained patient who was not a specified person.

[105] Quite properly, given the terms of the decision of the Supreme Court, Mr Campbell did not seek to argue that it was open to me to consider lines of argument of the sort that I have suggested in preceding paragraphs. I am conscious that these are undeveloped and have not been tested before me. So far as I can tell, the possible distinction between prohibition and restriction in the statutory language was not something put before the Supreme Court.

[106] I record that Mr Leighton initially made a submission under reference to *Padfield* v *Minister for Agriculture, Fisheries and Food* [1968] AC 997, to the effect that in prohibiting possession of sources of ignition the respondents were purporting to use a power granted for one purpose for an ulterior purpose. The ban on sources of ignition had been imposed to achieve by ulterior means the prohibition of smoking. As he recognised in the course of debate that his submission was that the prohibition was unlawful because the respondents were not using the appropriate statutory power available to them, rather than that they were purporting to do so for an impermissible purpose, he withdrew that submission.

The United Nations Convention on the Rights of Persons with Disabilities

[107] Mr Leighton submitted also that Article 5 of the United Nations Convention on the Rights of Persons with Disabilities ("UNCRPD") should inform my approach to all the grounds of challenge in this case, and in particular the various cases made under the 2010 Act. Article 5 provides:

> "1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
>
> 2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.
>
> 3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.
>
> 4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention."

[108] Mr Campbell submitted that the UNCRPD was an unincorporated treaty, conferred no justiciable rights and did not assist in the interpretation of domestic provisions. I accept that the UNCRPD is recognised by the European Court of Human Rights as part of the international law context within which the guarantees of the ECHR are to be interpreted: see, for example *P* v *Cheshire West* [2014] AC 896, at paragraph 36, referring to *Glor* v *Switzerland*, Application No 13444/04, 30 April 2009, at paragraph 53. It therefore has the potential to assist at least in the construction of the Convention rights, which form part of domestic law by virtue of the Human Rights Act 1998.

[109] The provisions of the 2010 Act reflect in a domestic context the international consensus expressed in Article 5 UNCRPD. They have as their object the equal protection under the law of persons with disabilities. So far as sections 15 and 19 are concerned, Mr Leighton recognised that it was difficult to advance his cases given the decision of the Supreme Court regarding Articles 8 and 14 ECHR. Section 149 again makes express reference to the need to eliminate discrimination. It refers particularly to meeting the needs of persons with disabilities. In the circumstances of this case I do not consider that any real assistance in construing any of the provisions of domestic law which I require to apply is to be derived from the terms of Article 5 UNCRPD.

Disposal

[110] Mr Leighton submitted that an award of damages (of £3000 in Mr A's case, and £500 in Mr B's case) was required in respect of each petitioner to afford just satisfaction. He had identified the figure by reference one of the categories identified in *Vento* v *CC West Yorkshire* [2003] ICR 318. Mr Campbell submitted that a finding of a breach would constitute just satisfaction. He referred to *Beggs* v *Scottish Ministers (No 2)* 2016 SLT 789 in which the

Lord Ordinary made a finding of breaches of the petitioner's Article 8 rights, rather than pronouncing a declarator to that effect. The respondents in that case had sought to persuade her that a declarator would serve no purpose, and that the court should not pronounce futile orders.

[111] The orders which a court may make in Scottish judicial review procedure are orders which are not peculiar to that procedure, or to cases involving Scottish public law. That is unsurprising given the origins and evolution of judicial review in Scotland. While a particular procedure for invoking the supervisory jurisdiction of the Court of Session was introduced in 1985, its introduction did not change the substantive law or introduce new remedies. I can see no obvious basis for making a finding rather than pronouncing a declarator as to the lawfulness of impugned conduct, where no other remedy falls to be granted. Declarator in proceedings of this sort provides a mechanism for expressing the court's finding. I do not regard it necessarily as futile to use that mechanism to that end.

[112] In this case, however, there is a decision which falls to be reduced as unlawful. Reduction of the decision to prohibit possession of sources of ignition is an order sought by the petitioner in paragraph 3(c) and plea in law 11 of Mr A's petition. There is a curiosity in the pleadings in Mr B's petition in that paragraph 4 of it, which lists the remedies sought, seems to focus on the ban on possessing tobacco, whereas the averments in paragraph 14, and all the submissions made to me, deal with the ban on possessing sources of ignition. Plea in law 8 is the relevant plea in his case. Mr Campbell did not take any point about this feature of the pleadings in Mr B's case. I do not regard the inconsistency I have identified as preventing me from reducing the decision to prohibit possession of sources of ignition at Leverndale. As I am reducing the decisions, I see no need to pronounce a separate declarator.

[113] I have determined that the comprehensive ban on smoking is lawful and does not breach the petitioners' rights. The prohibition on possession of sources of ignition is unlawful because it is not in accordance with domestic law. That conclusion results in my reducing the prohibition on sources of ignition. In those circumstances, I consider that damages are not necessary to afford just satisfaction.