

Independent Working Group on Drug Consumption Rooms

*Paper F*

## **Setting up a drug consumption room**

*Legal issues*

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## Introduction

This paper considers a number of legal issues that are likely to arise in practice were premises to be established in England and Wales that enable persons to self-administer illicitly obtained heroin on site under medical supervision. Such premises exist elsewhere and they are variously styled ‘drug consumption rooms’, ‘drug injection rooms’, ‘safe injecting centres’, and ‘safe injecting facilities’. For convenience, this paper will refer to these facilities as ‘drug consumption rooms’ (DCRs). This paper is not concerned with ‘shooting galleries’ where users pay to inject on site. Such premises are unsanctioned by government (probably *operating* illegally), and medical supervision is slight to non-existent.

It is not the purpose of this paper to advance the case for or against drug consumption rooms. Goodwill on the part of those establishing and operating such rooms has been assumed.

Given that there is a wealth of published material concerning DCRs, it is surprising to find that information relating to the legal position of DCRs is relatively slender. Valuable contributions have been made by several commentators who have addressed the question of whether a government that sanctions (or fails to sanction) a DCR has complied with its international obligations under treaty. But it is important to know something about the *domestic* legal principles by which existing DCRs are sanctioned, and to learn from the experience of those who run DCRs of any legal problems and issues that they have encountered.

This paper draws on the experiences of three facilities. They have been chosen because the legal system in which each exists (Australia and Canada) is similar to the legal system of the United Kingdom. The first is the Medical Supervised Injecting Centre (MSIC) in Sydney, and the second is the project in Vancouver, Canada (Insite). The experience of a further facility at 327 Carrall Street, Vancouver, is instructive because, after approximately 18 months, as an unsanctioned facility it was forced to close. It is unclear whether closure was warranted, but Thomas Kerr, Megan Oleson and Evan Wood say:<sup>1</sup>

...the 327 Carrall Street SIS experience shows that this form of activism can prompt escalating police attention and harassment, indicating the need for: (a) a careful consideration of risks for those providing and accessing the harm-reduction service being operated; and (b) at times, legal support for activists.

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<sup>1</sup> “Harm-reduction activism: a case study of an unsanctioned user-run safe injection site”, *Canadian HIV/AIDS Policy Review*, Volume 9, Number 2, August 2004.

The 327 Carrall Street experience also shows the importance of ensuring that:

- (i) a DCR meets legal requirements;
- (ii) managers and staff receive the protection of the law in relation to acts which they must perform if the facility is to be viable and effective. Presumably this is what Kerr *et al.* mean when they refer to “legal support for activists”.

Given the controversy that surrounds DCRs, there is a high risk that a DCR will be susceptible to legal challenge (at least in its early years). Judicial scrutiny at some stage is inevitable. The MSIC has been the subject of at least two civil legal actions. The first was an attempt to stop the centre opening at all. The action was brought and funded by a business consortium, concerned about financial and social damage the centre might cause. The second action was more personal, brought by a barrister (Duncan) against the Director of the MSIC (Dr Ingrid Van Beek) and her publishers to prohibit the Director publishing a book in connection with the MSIC.<sup>2</sup>

Both the MSIC and the Vancouver facility have a formal legal base, that is to say each facility is formally sanctioned by the state to provide services in accordance with domestic legal rules (those rules having been adjusted, where necessary, to afford the facility a degree of legal protection). In Vancouver, legal adjustment has been achieved by ministerial order. In Sydney, changes were made to primary and secondary legislation.

### *The MSIC, Sydney*

The *Drug Summit Legislative Response Act 1999* amended the *Drug Misuse and Trafficking Act 1985* to enable the licensing and operation of the centre for a trial period of 18 months. The trial period was itself extended by primary legislation to the year 2007 (for example, by the *Drug Summit Legislative Response Amendment (Trial Period Extension) Act 2003*).<sup>3</sup>

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<sup>2</sup> An allegation of defamation, “application for injunction to restrain the further publication of a book that has been on sale for about 2 months - subject matter of public interest and concern - plaintiff in political arena”: *Duncan v Allen and Unwin* [2004] NSWSC 1069.

[http://www.worldlii.org/au/cases/nsw/supreme\\_ct/2004/1069.html](http://www.worldlii.org/au/cases/nsw/supreme_ct/2004/1069.html)

<sup>3</sup> That Act was later repealed by the Statute Law (Miscellaneous Provisions) Act 2004 – an exercise to tidy up the statute book – and the amendments made to the 1985 Act therefore endure.

Relevant offences in the Drug Misuse and Trafficking Act 1985 include:

Section 10 (1)	possess prohibited drug
Section 11 (1)	possess equipment to administer prohibited drug
Section 12 (1)	Self-administer/attempt to self-administer prohibited drug
Section 13 (1)	administer/attempt to administer prohibited drug to another
Section 14 (1)	permit another person to administer/attempt to administer to him/her prohibited drug
Section 18A (1) (a)	advertise/hold out that premises are available for use for the administration of prohibited drugs
Section 18A (1) (b)	cause/suffer/permit person to advertise/hold out that premises are available for use for the administration of prohibited drugs

Offences of drug trafficking are also particularised in the 1985 enactment.

The 1999 Act inserts Part 2A into the 1985 Act. Part 2A consists of 5 divisions, and 20 sections (namely s.36A–36T). Several sections are reproduced in this paper in **Appendix A**.

The MSIC must be licensed. The licence is subject to conditions. Protocols must be established, and no child must be admitted to the area used for the administration of drugs. Section 36N protects users from prosecution for possessing specified amounts of a drug, or possessing drug paraphernalia for use in connection with the administration of a drug. Section 36O exempts from *criminal liability* persons engaged in conduct of a licensed injecting centre. Section 36P gives similar exemption for *civil liability* in connection with conduct of a licensed injecting centre.

### *The Vancouver Project*

The main pillar of Canadian drug law is the Controlled Drugs and Substances Act (CDSA) 1996. Section 56 empowers a Minister to exempt “on such terms and conditions as the Minister deems necessary”

...any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the

Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.

On the 24<sup>th</sup> June 2003, the federal Minister of Health granted, in principle, the Vancouver Coastal Health Authority's application for an exemption under section 56 of the CDSA, to launch a supervised injection site pilot research project. The description of the facility as a "pilot research project" is important in the context of the terms of the three main UN drug control conventions.

Health Canada undertook to provide up to \$1.5 million over four years to support the evaluation component of the project. The Honourable Hedy Fry MP stated that:<sup>4</sup>

The goal of the project is to assess whether the establishment of a supervised injection site pilot research project in the Downtown Eastside of Vancouver will reduce the harm associated with illicit drug use, improve the health of drug users, increase appropriate use of health and social services by drug users and reduce the health, social, legal and incarceration costs associated with drug use.

It is plain that the decision to sanction the two DCRs was not taken lightly. The government was mindful of three main United Nations drug control conventions<sup>5</sup> to which Canada is a signatory.<sup>6</sup> The 1996 Act was itself passed with the conventions well in mind.

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<sup>4</sup> Press Release (PRESSI.COM 06/25/2003) Ottawa.

<sup>5</sup> The *Single Convention on Narcotic Drugs*, 1961 as amended by the 1972 Protocol, the *Convention on Psychotropic Substances*, 1971, and the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988.

<sup>6</sup> "Health Canada is a partner in strategies directed at the appropriate management of controlled drugs and substances, both at the international and national levels. At the international level, Canada is a signatory to three international drug control conventions: the Single Convention on Narcotic Drugs, 1961 as amended by the 1972 Protocol, the Convention on Psychotropic Substances, 1971, and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. As such, Canada must comply with the requirements of these conventions. Health Canada is the designated Canadian 'competent authority' for the administration of these conventions in Canada." (Interim Guidance Document for an application for an exemption under Section 56 of the Controlled Drugs and Substances Act for a scientific purpose for a pilot supervised injection site research project).

Health Canada published notes for guidance in respect of applications for exemption (pursuant to section 56 of the CDSA 1996), in which the following passage appears:<sup>7</sup>

The Federal/Provincial/Territorial (F/P/T) Conference of Deputy Ministers of Health tasked the F/P/T Committee on Injection Drug Use (IDU) with examining the issue of injection drug use. The report of this group, *Reducing the Harm Associated with Injection Drug Use in Canada*, provides a comprehensive framework to reduce the harm associated with injection drug use in Canada. Implementation of the framework requires multi-sectoral and interjurisdictional integration, coordination and complementarity of a diverse array of strategies at the local, provincial/territorial, national and international levels. The F/P/T report was presented to the Conference of Deputy Ministers of Health in June, 2001 and released by the Conference of Ministers of Health in September 2001. Pilot supervised injection sites are included in the potential strategies identified in the F/P/T report.

The Notes address the problem that a DCR might operate illegally without legislative intervention:

Because there are no regulations applicable to SISs, the operation of a SIS would be considered illegal under the CDSA, as would the activities of drug users in respect of possession of substances controlled under the CDSA. However, section 56 of the CDSA gives the Minister the authority to exempt, on such terms and conditions as the Minister deems necessary, persons from the application of all or some of the provisions of the Act if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest. Health Canada will use this provision to enable the conduct of the pilot scientific, medical research projects recommended to evaluate SISs as a means to reduce the harm associated with injection drug use. Exemptions under section 56 for scientific purposes would be the most consistent application of the provision in regard to pilot SIS research projects.

But the Notes also make the point that [emphasis added]:

**Exemptions under section 56 are not a mechanism to encourage or promote the use of controlled drugs or substances.** Because these are pilot research projects, Health

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<sup>7</sup> 29<sup>th</sup> December 2002.

Canada anticipates that only a small number of applications for exemption under section 56 for a pilot SIS research project will be submitted.

A DCR, which has been set up and sanctioned in this way, demonstrates that the government is not only mindful of its international obligations, but it has also carried out risk and benefit assessments. Either assessment might be wrong, but as the Notes stress, what is being sanctioned is a pilot - for the purposes of scientific research. A decision to extend (or not to extend) the trial will thus be informed in the light of the data obtained. In this way, Canada believes that it has complied with the UN conventions. The INCB (International Narcotics Control Board) disagrees.

### **DCRs: the three UN conventions, and international commitment**

Although much has been written about the three main United Nations conventions, there is a tendency (understandably perhaps) to focus on those parts of the conventions that impose restrictions and prohibitions, at the expense of other parts that permit actions to be performed in the interest of health and welfare. Conventions, in common with many formal documents, need to be given a purposive interpretation. Those conventions are not all about prohibition. Where there is prohibition, it is prohibition with a view to promoting public health and wellbeing.

When considering the three UN conventions, it must be remembered that in English law all Acts of Parliament are presumed to be local unless the statute in question states otherwise. None of the three main United Nations conventions has direct application in the United Kingdom. Insofar as a statute purports to give effect to a treaty, domestic courts will first look to the language of the statute. The courts will assume that the Legislature, when drafting a Bill, was alive to its international obligations. In any event it is a mistake to construe treaty provisions as if they were sections in a domestic statute. Conventions often embody statements of political will, intent, or hope.

There are aspects of the three UN drug control conventions that are distinctly open ended. The 1988 Convention was in part an attempt to bring the two earlier conventions into line with each other and with the 1988 Convention.

The *Runciman Independent Inquiry into the Misuse of Drugs Act 1971* examined the conventions<sup>8</sup> and commissioned *European Drug Laws: Room to Manoeuvre* – a substantial comparative study of drug law in several EU countries.<sup>9</sup> The study revealed that the three United Nations conventions leave more room for manoeuvre than might be supposed. Thus, in the drafting of offences, the mental ingredient required to be proved by the prosecution, the classification of drugs, the penalties to be imposed on offenders (or even whether there should be a prosecution at all) are matters usually left to the discretion of Contracting States.

All commentators agree that the three United Nations conventions focus on trafficking – particularly where there is a commercial element. The INCB has asserted that DCRs are not convention compliant because they are liable to “facilitate illicit drug trafficking”.<sup>10</sup> This is presumably on the basis that if there were no buyers of illegal drugs there would be no illegal drug suppliers. This is a matter of evidence, not a matter of legal principle. It would be relevant to establish – if it can be established – whether the existence of DCRs increase or decrease the incidence of illegal drug trafficking. The INCB is silent on the point.

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<sup>8</sup> “Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971”, Chair: Viscountess Ruth Runciman DBE, Police Foundation Report, 2000.

<sup>9</sup> Published by DrugScope, edited by Nicholas Dorn and Alison Jamieson. See also the article by Neil Boister, *Decriminalising the personal use of cannabis in the United Kingdom: does international law leave room to manoeuvre?* [2001] Crim.L.R.171.

<sup>10</sup> “176. Drug injection rooms, where addicts may inject themselves with illicit substances, are being established in a number of developed countries, often with the approval of national and/or local authorities. The Board believes that any national, state or local authority that permits the establishment and operation of drug injection rooms or any outlet to facilitate the abuse of drugs (by injection or any other route of administration) also facilitates illicit drug trafficking. The Board reminds Governments that they have an obligation to combat illicit drug trafficking in all its forms. Parties to the 1988 Convention are required, subject to their constitutional principles and the basic concepts of their legal systems, to establish as a criminal offence the possession and purchase of drugs for personal (non-medical) consumption. By permitting drug injection rooms, a Government could be considered to be in contravention of the international drug control treaties by facilitating in, aiding and/or abetting the commission of crimes involving illegal drug possession and use, as well as other criminal offences, including drug trafficking. The international drug control treaties were established many decades ago precisely to eliminate places, such as opium dens, where drugs could be abused with impunity.

177. The Board, recognizing that the spread of drug abuse, human immunodeficiency virus (HIV) infection and hepatitis are serious concerns, encourages Governments to provide a wide range of facilities for the treatment of drug abuse, including the medically supervised administration of prescription drugs in line with sound medical practice and the international drug control treaties, instead of establishing drug injection rooms or similar outlets that facilitate drug abuse.” (INCB Report 1999, page 26/27). See also Report 2000, para.176, page 26.

In its most recent report, the INCB has again expressed its “concern” over drug injection rooms, albeit that the manner of the objection is somewhat less dogmatic than hitherto:<sup>11</sup>

510. The establishment of rooms for drug injection, consumption and/or inhalation or other facilities where illicit drugs are administered continues to be a contentious issue, particularly in the member States of the European Union. While it is sometimes argued that drug injection rooms have some positive effects, such as establishing contact between social services and the hard-to-reach population of injecting drug abusers, the provision of such facilities raises legal and ethical issues. Drug injection rooms are legal facilities for the purpose of facilitating behaviour that is both illegal and damaging. The drugs used in those facilities come from the illicit market. The Board notes that the Governments of many European countries with drug control policies as diverse as those of Denmark and Portugal have opted against the establishment of drug injection rooms, and the Board strongly supports their decisions. The Board also reiterates that drug injection rooms are against the central principle embodied in the international drug control treaties, namely that the use of drugs should be limited to medical and scientific purposes only.

*The complaint that “DCRs facilitate illicit drug use”*

Commentators have made two main points in answer to the complaint that DCRs facilitate illicit drug use. The first point is that the function of a DCR is not to promote or to encourage drug use, or even to indulge it, but to reduce harm associated with intravenous drug use. This, it is said, is legitimate action within the terms of the three main UN drug control conventions and human rights instruments. The second point is that the UN conventions require universal action to control the illicit trafficking of scheduled substances, but in relation to “use” and “consumption”, each signatory is competent to impose measures that may be required to reduce demand, and to reduce personal harm (“degradation and social disruption”<sup>12</sup>).

The second point is frequently accompanied by the proposition that the UN conventions do not require signatories to criminalise the possession of drugs for personal use, or actual use, or the consumption of scheduled drugs. Without wishing to minimise the importance of this topic, it is – for present purposes – unhelpful and unnecessary to seek to

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<sup>11</sup> E/INCB/2004/1, para.510, 511.

<sup>12</sup> See Resolution III, Single Convention 1961.

persuade governments that the proposition is true. The reality is that most governments have criminalised, and will continue to criminalise, the possession and supply of substances particularised in the UN conventions. But drug control in the United Kingdom – like the conventions – is not all about prohibition. Although the MDA imposes general prohibitions in respect of particular actions (e.g. supply), there are numerous Regulations made under the 1971 Act that grant exemptions and exceptions to those prohibitions. The MDA 1971 was intended to be a highly flexible drug control mechanism; in practice it is as flexible as the will of the government. The same might be said of the legislative scheme in Canada (see s.56, CDSA 1996) and in Australia.

In respect of actions to promote health and welfare, Article 36.1(b) of the Single Convention, provides that:

...when abusers of drugs have committed [offences], the Parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration.

As originally drafted, the Single Convention in 1961 did not include this provision. It was added by the 1972 Protocol. What, therefore, is its purpose? The most logical answer is that it ensures that drug use is not seen as just a 'crime' issue, but a health and education issue too. Similar provision exists in the 1971 Convention in respect of psychotropic substances. It therefore made good sense to make the Single Convention consistent in that regard (see Noll, *Drug Abuse and Penal Provisions of the International Drug Control Treaties*, Bulletin on Narcotics, Issue 4-003, 1977).

It is arguable that Article 36.1(b) only makes sense if domestic law punishes possession for personal consumption/use, but even in the absence of such an offence, Article 38(1) of the Single Convention<sup>13</sup> places a general responsibility on all signatories to take practical measures for the prevention of drug abuse, and to advance rehabilitation and social reintegration.<sup>14</sup>

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<sup>13</sup> Mirrored in Art.20 of the 1971 Convention.

<sup>14</sup> "The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends."

We should not lose sight of the fact that the Preamble to the 1971 Convention notes, “with concern the public health and social problems resulting from the abuse of certain psychotropic substances”.

We should also note the extent to which the health and welfare of addicts was in the minds of delegates who attended the 1972 UN Conference,<sup>15</sup> for the purpose of amending the 1961 Single Convention. They resolved (Resolution III) that:

*Recalling* that the Preamble to the Single Convention on Narcotic Drugs, 1961, states the Parties to the Convention are “concerned with the health and welfare of mankind” and “are conscious of their duty to prevent and combat” the evil of drug addiction,

*Considering* that the discussions at the conference have given evidence of the desire to take effective steps to prevent drug addiction;

*Considering* that, while drug addiction leads to personal degradation and social disruption, it happens very often that the deplorable social and economic conditions in which certain individuals and certain groups are living predispose them to drug addiction,

*Recognising* that social factors have a certain and sometime preponderant influence on the behaviour of individuals and groups,

*Recommends that the Parties:*

1. Should bear in mind that drug addiction is often the result of an unwholesome social atmosphere in which those who are most exposed to the danger of drug abuse live;
2. Should do everything in their power to combat the spread of the illicit use of drugs;
3. Should develop leisure and other activities conducive to the sound physical and psychological health of young people.

It has been said that drug consumption rooms aim to:

- (1) promote a safer and cleaner injection environment;
- (2) prevent the spread of highly infectious diseases (some of which may be life threatening);
- (3) prevent drug related deaths or physical harm;

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<sup>15</sup> Geneva: between the 6th and 24th March 1972.

- (4) “provide a gateway through which injecting drug users can access the healthcare system” [Perry Bulwer, *Compelling the Government to Act*].

Neil Hunt, in a paper for the Beckley Foundation (2003), wrote:<sup>16</sup>

There is good evidence that, when developed in consultation with the wider community, a range of operational models for DCRs is possible, and these can serve differing populations and local needs. Data concerning the number of visits they receive provides evidence of the amount of injecting that is transferred to a safer environment, probably decreasing nuisance and in which skilled personnel with access to emergency equipment are in attendance. Consumption rooms also have a demonstrated capacity to attract more marginalised and vulnerable drug users. There are indications that they are likely to have an impact on overdose deaths and may reduce risk behaviours for blood borne viruses. However, these cannot yet be well quantified. Beyond this, they can provide access to a range of drug treatment, health and social care services. As yet, the cost-effectiveness of consumption rooms is uncertain. Whilst they show promise, further research is required to clarify their overall impact and value for money.

It is not just the life, health, and welfare, of the drug-injecting user that is to be protected, but the wellbeing of persons with whom the user associates (particularly in the context of intimate relationships).

Resolution III is helpful when considering whether or not the sanctioning of a DCR infringes or meets a state’s obligations under the three UN conventions. The unwholesome atmosphere in which users live is a relevant consideration. Given that it is incumbent on governments to do everything in their power to combat the spread of the illicit use of drugs,<sup>17</sup> policy makers might wish to consider whether it is also incumbent on governments to prevent the spread of highly contagious dangerous diseases, and drug related harms.

The main aims of the 1988 Convention are to:

- (i) clarify ambiguities in the 1961 and the 1971 Conventions;
- (ii) strengthen mutual assistance and enforcement; and

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<sup>16</sup> Beckley Foundation Drug Policy Programme: A DrugScope Briefing Paper No. 3, 2003.

<sup>17</sup> Resolution III, para.2.

- (iii) introduce *new* obligations [viewpoint 1], or restate obligations already required by earlier conventions [viewpoint 2], or both [viewpoint 3].

The 1988 Convention recognises that each Party is “equal” and “sovereign”. Accordingly, each Party must act in a manner that conforms to “the fundamental provisions of [the Parties] respective domestic legislative systems”: Article 2.1 and Article 2.2.

Some activities fall outside the conventions. One example relates to section 8 of the MDA 1971 by which it is an offence for occupiers or those concerned in the management of premises, to permit or to suffer specified actions to take place there. Note that the conventions do not require the provision of equipment for the consumption, or the administration of drugs, to be prohibited.

Whether, by establishing and sanctioning a DCR, a government acts contrary to obligations under the three UN conventions depends partly on the purpose of the DCR, and partly on the nature of the activities that take place there. Regard must be given to the effect that a DCR will have on the community.

If the only test for compliance is whether a particular DCR is conducive to rehabilitation and social integration, the position would be as stated by the Swiss Institute of Comparative Law [emphasis added]:<sup>18</sup>

For the purposes of this legal opinion, much therefore depends upon the issue of how best to care for drug abusers and how to induce them into rehabilitation. The 1961 and 1971 Conventions simply ask for the rehabilitation and social reintegration of addicts, without indicating how these objectives should be attained. Art.14 of the 1988 Convention is entitled, “Measures to ... eliminate illicit demand for narcotic drugs and psychotropic substances” and might be expected to contain concrete policy choices. Unfortunately, para. 4 simply exhorts States Parties to “adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic sub-stances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic” and the choice of such measures is left entirely to the discretion of States Parties. **No guidance at all is provided to the persons who must decide whether or not state-controlled public injection rooms are conducive to the**

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<sup>18</sup> Swiss Institute of Comparative Law, AVIS 99-121c January 7, 2000. *Use of Narcotic Drugs in Public Injection Rooms under Public International Law.*

**rehabilitation and social reintegration of addicts, to the reduction of human suffering and to the elimination of financial incentives for illicit traffic. This is indeed not a legal question at all, in the sense that medical experts, social workers and health policy makers are much better equipped than lawyers to provide reliable responses.** Our Institute is certainly not in any position to provide a concrete response. The recent letter of the International Narcotics Control Board addressed to the Danish Minister for Health must be read in the same light. The operative third paragraph, considering public injection rooms, is an opinion on drug policy, reflecting certain implicit policy choices as to optimal policing practice and socio-medical treatment of drug users. It is neither a statement of public inter-national law, nor, in the quality of an opinion of the INCB, itself legally binding upon Denmark or any other State.

However, rehabilitation and social integration are not the only factors to be considered. The conventions represent a package of measures designed to regulate the production and distribution of scheduled drugs. One of the principal aims of the conventions is to limit the use of scheduled drugs to medical and scientific purposes: see, for example, Article 5 of the 1971 UN convention. It will be recalled that in its 2004 Report, the INCB speaks of the “central principle embodied in the international drug control treaties, namely that the use of drugs should be limited to medical and scientific purposes only.”<sup>19</sup> Even if we give the INCB the advantage that this principle is indeed central, it is for governments to decide whether the *overarching* objective of the conventions is the “health and welfare of mankind”.<sup>20</sup> The central principle is meaningless without the context in which it exists, and in this instance, the context might be said to be health and welfare.

The history of attempts to regulate the use of heroin is relevant. Heroin appears in schedule IV and Schedule I of the 1961 Single Convention. The Official Commentary to that convention states why heroin, and certain other drugs, appear in Schedule IV:

6. Whether the prohibition of drugs in Schedule IV (Cannabis and cannabis resin, desomorphine, heroin, ketobemidone) should be mandatory or only recommended was a controversial question at the Plenipotentiary Conference . This was a continuation of a long-lasting international controversy regarding the usefulness of

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<sup>19</sup> INCB Report 2004, Para..510.

<sup>20</sup> To use the language of Resolution III.

prohibiting particularly dangerous drugs without therapeutic properties not obtainable from other less dangerous substances.

A proposal to abolish the use of heroin was made as early as 1923 in the League of Nations' Advisory Committee on Traffic in Opium and Other Dangerous Drugs. Such proposals were also made at the Geneva Conferences of 1924/25 and of 1931, which respectively concluded the 1925 and 1931 Convention, but were not adopted.' The 1931 Conference, by way of compromise, included article 10 in the 1931 Convention, imposing a particularly restrictive regime on the international trade in heroin (diacetylmorphine). Under this provision exports of diacetylmorphine and of its preparations were prohibited. The only exception was for shipments to a country which did not manufacture the drug. Moreover only such quantities could be exported as were necessary for the importing country's medical and scientific needs. The shipment had to be specially requested by the Government of that country, and consigned to the Government Department indicated in the import certificate. The Conference also adopted a recommendation (VI) to the effect that each Government should examine in conjunction with the medical profession the possibility of abolishing or restricting the use of heroin.

While opposition to the discontinuation of the use of heroin was formerly based on the assertion that it still had some specific medical value not obtainable from other less dangerous drugs, **more recent objections rested on the belief that the decision regarding prohibition should be left to the judgment of each Government, and that international organs should limit themselves to recommending prohibition where advisable, but should not be authorized to prescribe it in a mandatory manner.** In fact, this was also the position of those delegates to the Plenipotentiary Conference who opposed a provision in the Third Draft of the Single Convention which would have established a mandatory prohibition of the production, manufacture of, trade in, possession and use of drugs in Schedule IV except for small amounts for research purposes. The opponents included representatives of States which in fact had adopted the prohibitions in question. **Article 2, paragraph 5, subparagraph (b) constitutes a compromise which leaves prohibition to the judgement, though theoretically not to the discretion, of each Party.**

7. In the post-war period, international efforts to bring about the discontinuation of the use of heroin were extended to other drugs. In line with those endeavours, the Plenipotentiary Conference included in Schedule IV cannabis and cannabis resin, desomorphine (dihydrodesoxymorphine), and ketobemidone.

**8. For a considerable period of time-and still at the time of writing there has been no significant diversion of legally manufactured drugs from legal trade into illicit channels; but if a Government were unable to prevent such a diversion of drugs in Schedule IV, a situation would arise in which the measures of prohibition mentioned in subparagraph (b) would be "the most appropriate means of protecting the public health and welfare". Whether this was or was not the case would be left to the judgement of the Party concerned whose bona fide opinion on this matter could not be challenged by any other Party.**

9. Another situation in which measures of prohibition would be "appropriate" for the protection of public health and welfare might exist where the members of the medical profession administered or prescribed drugs in Schedule IV in an unduly extensive way, and other less radical measures, such as warnings by public authorities, professional associations or manufacturers, were ineffective. It may however be assumed that such a situation could rarely if ever arise.

Accordingly, Article 2(5)(b) of the 1961 Single Convention (that concerns Schedule IV substances), states:

A Party shall, if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import of, trade in, possession or use of any such drug except for amounts which may be necessary for medical and scientific research only, including clinical trials therewith to be conducted under or subject to the direct supervision and control of the Party.

It has to be recognised that conditions in 1961, in relation to the production, trafficking, and use of heroin, differ markedly from the conditions that now prevail. But mindful of the context in which Article 2(5)(b) appears in the 1961 Convention, the fact remains that the Article (if engaged) requires governments to make informed decisions about the action it should take in order to protect public health and welfare. This it can only do by careful research. Scientific research is not outlawed by

any of the conventions, but opinions differ as to what “scientific research” in this context actually means. However, it was against this background that the Canadian Safe Injection Facility was granted exemption under section 56 of the CDSA 1996.

The INCB has not accepted that DCRs are convention-compliant, but in the first instance, it is for each Party to decide for itself whether its drug control programme meets international obligations. The United Kingdom has introduced legislation that exceeds the requirements of the three UN conventions. Regulations might disapply section 5(2) [simple possession] in respect of staff working at the facility, and in respect of attendees in possession of a small amount of heroin. But an alternative approach (so far as attendees are concerned) is to draw up an appropriate policing protocol between the DCR, the police, and the local authority. Either approach does not take the United Kingdom down the path of legalising possession.

### **Is a government duty bound to support the existence of a DCR?**

The issue here is whether a government is duty bound to support the existence of a DCR in order to comply with its domestic and international human rights obligations.

In a well-researched article, Richard Elliott, Ian Malkin, and Jennifer Gold argue “the conventions themselves permit the establishment of such facilities as a step toward fulfilling our international human rights obligations”.<sup>21</sup> Perry Bulwer in his equally thoughtful article,<sup>22</sup> goes further and says:

Under the human rights legislation the basic argument is that the government has a duty to accommodate IDU’s as disabled persons by establishing SIF’s and thereby removing the discriminatory effect of lack of access to necessary medical services.

Article 55 of the *Charter of the United Nations* states that:

With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among

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<sup>21</sup> *Establishing Safe Injection Facilities in Canada*, Canadian HIV/AIDS Legal Network..

<sup>22</sup> Perry Bulwer, “Safe Injection Sites: Compelling the Government to Act” <http://www.pivotallegal.org/research/PerryBulwer-CompellingAction.html>.

nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

- a. higher standards of living, full employment, and conditions of economic and social progress and development;
- b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and
- c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

Article 12 of the *International Covenant on Economic, Social and Cultural Rights*, states:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
  - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
  - (b) The improvement of all aspects of environmental and industrial hygiene;
  - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
  - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The *General Comment No. 14 of the UN Committee on Economic Social and Cultural Rights* states:<sup>23</sup>

...genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

Eloquent as the above statements are, the fact is that the United Kingdom already provides a “variety of facilities” and services. It is highly improbable that a court would say that the absence of a DCR in

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<sup>23</sup> E/C.12/2000/4; 11 August 2000.

the United Kingdom would infringe the above-mentioned Articles, or the ECHR, or the Human Rights Act 1998.

In Canada, there has been some judicial comment that drug addicts suffer from a disability: *Regina v Nguyen* (1995) 56 BCAC 290; *Regina v Ping Li* (unreported, 19th November, 1993), but neither the courts in Canada, nor in Australia, have declared that domestic government is under a duty to provide health services *of a particular kind* to persons living or working in territory under its control.

The European Convention on Human Rights has been incorporated into the law of the United Kingdom by the Human Rights Act 1998. The following Articles are usually cited in support of the existence of a DCR:

Article 2(1) provides that:

Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

Article 3 (degrading treatment) provides that:

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Article 5(1) (liberty and security) provides that:

Everyone has the right to liberty and security of the person ...

Article 8 provides that:

(1) Everyone has the right to respect for his private and family life, his home and his correspondence.

(2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

It is to be noted that the Human Rights Act 1998 imposes a duty on "public authorities" to comply with articles of the ECHR that have been incorporated into United Kingdom law.

## Government departments as ‘public authorities’

The definition of a ‘public authority’ is widely construed, and includes services provided or regulated by government.<sup>24</sup> However the provisions of the European Convention of Human Rights do not necessarily bind individuals, or legal persons, unless they perform functions of a public nature [see section 6 (3) (b), section 6 (5), Human Rights Act 1998]. So is the Home Office, or the Department of Health, under an obligation to support the existence of a DCR?

There is some support for the view that the failure of a public authority to provide proper care, in a case where someone is suffering from serious illness, could in certain circumstances amount to ‘treatment’, contrary to Article 3 of the European Convention on Human Rights: *Tanko v Finland* (Commission, May 19th, 1994).

In *D v United Kingdom* (ECtHR, 27th April, 1997), the court held that to return D to St Kitts from with the United Kingdom would hasten his death on account of the unavailability of similar treatment for AIDS in St Kitts, and therefore breach Article 3. The court described the facts in a ‘D’ as “exceptional”.

It must be noted that the level of protection afforded by the articles of the ECHR represents an irreducible minimum, allowing for a margin of consideration between member states to regulate their own affairs having regard to the resources available to them (among other considerations). In short, the United Kingdom already provides treatment programmes in connection with drug misuse and drug addiction such that it is highly improbable that the ECHR could be successfully invoked to compel the government of the United Kingdom to establish, and to support the running of drug consumption rooms. Neither is it likely that the courts of the United Kingdom would allow Articles of the ECHR to be used as general defences to a ‘criminal charge’, or a ‘civil action’, brought against a person who participated in the running of a drug consumption room. That is likely to be the position even if it could be established that drug consumption rooms are preferable to current injecting practices employed by many drug users.

In the context of Canadian law Perry Bulwer advances an attractive argument that existing laws in that country might “support an action against the government compelling it to establish SIFs”.<sup>25</sup> Bulwer cites

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<sup>24</sup> Neither House of Parliament is a ‘public authority’ except to the extent that the House of Lords acts in its judicial capacity; section 6 (3), (4), Human Rights Act 1998.

<sup>25</sup> Perry Bulwer, “Compelling the Government to Act”, <http://www.pivotal.org/research/PerryBulwer-CompellingAction.html>.

the Canadian cases of *Morgentaler*, *Rodriguez v British Columbia*, and *Parker*.

In *Regina v Morgentaler* [1988] 1 SCR 30, Beetz J. said:

...“Security of the person” must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction.

In *Rodriguez v British Columbia (A.G.)*, Sopinka J, speaking for the majority, said:

There is no question, then, that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these.

In *R v Parker* [2000] O.J. No.2787 (Ontario, Court Appeal), the appellant used marijuana for medical purposes. Rosenberg J.A., referred to *Morgentaler* and *Rodriguez*, and remarked:

...deprivation by means of a criminal sanction of access to medication reasonably required for the treatment of a medical condition that threatens life or health constitutes a deprivation of the security of the person... Depriving a patient of medication in such circumstances, through a criminal sanction, also constitutes a serious interference with both physical and psychological integrity.

These cases are at best persuasive in the courts of the United Kingdom, but they do not bind them. As the Court of Appeal remarked in *Quayle* (see below).<sup>26</sup>

We are also not the same position, evidentially or above all legally, as the Canadian courts. This is apart from obvious distinctions between the terms of, and the role and powers of the Canadian court under, the Canadian Charter compared with those of, and of the English court under, the Human Rights Act 1998 incorporating the European Convention on Human Rights into United Kingdom law.

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<sup>26</sup> [2005] EWCA Crim 1415 Para.65.

The fact is that UK courts have been largely supportive of Parliament's approach to drug control, and in a series of cases, the courts have held that United Kingdom drug laws are ECHR compliant. The one exception relates to a reverse burden provision in the MDA 1971, namely s.28, and even here the House of Lords was able to read down the section so that it imposes an evidential burden only: *Lambert* [2001] UKHL 37.

In the recent case of *Quayle*,<sup>27</sup> the Court of Appeal rejected the contention that conduct unlawful under the MDA 1971 could be "excused or justified by the need to avoid a greater evil". *Quayle* examined complex issues about the availability and extent of any defence of medical necessity. Three of the appellants ('Q', 'W' and 'K') used cannabis to alleviate pain:

- 'Q' cultivated cannabis following a bi-lateral below-knee amputation;
- 'W' fractured two vertebrae in the Navy. He broke five further vertebrae in a traffic accident in 1981. He contracted tuberculosis resulting in lung scars and breathing problems in 1983. He had a further accident lacerating his tendons and breaking his left wrist. He later developed chronic pancreatitis for alcohol-related reasons, depression, and chronic ('life-threatening') pain. His liver was damaged by hepatitis B. He was suffering from rheumatoid arthritis, osteoporosis and osteoarthritis;
- 'K' injured his back picking up a piece of glass at work.

Following a detailed review of the authorities, legislative framework, and authoritative reports,<sup>28</sup> the Court said:

66. We have not had put directly before us under s.5 of the 1998 Act any issue as to the compatibility or otherwise of any aspect of the United Kingdom's current drug legislation with the European Convention on Human Rights. We have not been put in a position procedurally in which we could determine any such issue. Nor has it been suggested that the legislation can be read down or qualified, so as to create an exception permitting self-prescription or prescription by persons other than doctors in cases of exceptional pain where cannabis offers the only or the best means of avoiding or alleviating the pain. The suggestion is that, whatever the legislative policy and scheme, we should interpret or extend

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<sup>27</sup> *Quayle* [2005] EWCA Crim 1415 (unreported, 27th May, 2005).

<sup>28</sup> For example, the Runciman Independent Inquiry Report, into the Misuse of Drugs Act 1971 (2000, Police Foundation).

the common law defence of necessity so as to avoid a suggested inconsistency with article 8.

67. The legislative policy and scheme are clear. We have accepted that this does not mean that a common law defence of duress by threats or necessity by extraneous circumstances can never have a place (paragraph 57 above). But its role cannot be to legitimise conduct contrary to the clear legislative policy and scheme, as would in our view be the effect of the defences suggested in the appeals and reference before us for reasons given in paragraph 56 above. We see no basis in article 8 for altering our conclusions regarding the scope and the inapplicability of the common law defence of necessity by extraneous circumstances in the context of the present appeals and reference.

68. We add only this with regard to the evidence before us. We have been shown a good deal of material, much of it summarised earlier in this judgment. The issues which would be involved in considering the compatibility with the Convention of the United Kingdom's drug legislation if there is no relevant common law defence of necessity are not straightforward. Interference with the right to respect for private life is permissible under article 8(2) if 'in accordance with the law and ... necessary in a democratic society ... for the prevention of disorder or crime, for the protection of health or morals, or the protection of the rights and freedoms of others'. Within the limits indicated in *Taylor (Joseph) v. Lancashire County Council* [2005] EWCA Civ 284, the court's decision would involve an evaluation of the medical and scientific evidence, a weighing of the competing arguments for and against the immediate change recommended by the Select Committee and the Runciman Committee, a greater understanding of the nature and progress of the tests of cannabis which have taken and are taking place, and a recognition that, in certain matters of social, medical and legislative policy, the elected government of the day and Parliament are entitled to form overall policy views about what is best not just for particular individuals, but for the country as a whole, in relation to which the courts should be cautious before disagreeing.

69. On the material before us, so far as it is appropriate for us to express any view, we would not feel justified in concluding that the present legislative policy and scheme conflict with the Convention. That is so, even if there is no common law defence of medical necessity such as that for which the appellants and Mr Ditchfield contend. We would not feel justified in concluding that either Parliament or the Secretary of State has acted inappropriately or

delayed unduly in maintaining the present general policy and scheme up to the present date pending the outcome of and decisions on the basis of tests which are, we are told, still on-going.

70. For these reasons, we do not consider that the submissions based on the European Convention on Human Rights assist the appellants.

The Court held that the defences of necessity or "duress of circumstances" should be confined to cases where there was a compelling need to avoid imminent danger of physical injury.

## The Main Offences

### *Offences*

The main offences under the Misuse of Drugs Act 1971 are:

- (1) Simple possession: section 5.
- (2) Supply: section 4.
- (3) Being concerned in the supply of a controlled drug: section 4.
- (4) Offering to supply a controlled drug: section 4.
- (5) Production of a controlled drug: section 4.
- (6) Providing paraphernalia for Class A drug consumption: section 9A.
- (7) Permitting or suffering premises to be used for certain prohibited purposes: section 8.
- (8) Exporting or importing controlled drugs: section 3.
- (9) Incitement to commit a Misuse of Drugs Act offence: section 19.

Other relevant offences (not under the MDA) are:

- (1) Administering a noxious substance: section 23, Offences Against the Person Act 1861.
- (2) Manslaughter by an unlawful and dangerous Act, or by gross negligence.
- (3) Various offences under the Medicines Act 1968.

### *The nature of heroin and cocaine*

Both heroin and cocaine are Class A controlled drugs for the purposes of the Misuse of Drugs Act 1971, related enactments, and statutory instruments. Those two substances are also “Medicinal Products” for the purposes of the Medicines Act 1968.

“Preparations” and “products” containing any controlled drug, are also controlled under the Misuse of Drugs Act 1971. A “preparation” is any act performed by a human being that puts a substance into a form ready for consumption. The act of mixing heroin, water, and citric acid, is an act of preparation.

Preparing a drug may or may not be, an active “production” contrary to section 4 of the Misuse of Drugs Act 1971 (a drug trafficking offence). Heroin in solution is a “preparation”. It may also be a “product” if (for example) it is bottled, or perhaps stored in a fridge. Crushing pills to put them into a form ready for consumption will also be an act of “preparation”. The law in relation to “preparations” and “products” is not as well developed as it might be.

Cocaine in all its forms is still 'cocaine'. Converting either substance into base, or a salt, or the other way round, is an act of production: *Greensmith* [1983] 1 W.L.R. 1124.

The above matters when considering section 8 of the Misuse of Drugs Act 1971 (that prohibits managers and occupiers of premises "permitting or suffering" the production of drugs on premises).

### Protecting DCRs in respect of MDA offences

Legislative protection could be given to drug consumption rooms by amending the Misuse of Drugs Regulations 2001 so as to exempt managers and staff from the provisions of section 5(2) [possession], section 5(3) [possession with intent to supply], section 4(3)(a) [supply or making an offer to supply], section 4(3)(b) [being concerned in the supplying of a controlled drug], section 4(3)(c) [being concerned in the making of an offer to supply], section 4(2) [production], section 9A [providing paraphernalia for administration], and section 8 [premises].

### *The offence of unlawful possession*

As a general rule, a person is in possession of an item if he has custody of it, or he exercises control over it (see section 37, and Misuse of Drugs Act 1971). He must know of the existence of the item, but a mistake as to its quality (for example, mistaking cocaine for amphetamine) will only be a defence if he had no reason to suspect that the substance was a controlled drug at all (a statutory defence under section 28 of the Misuse of Drugs Act 1971). Section 28 imposes an evidential burden only: i.e. a defendant need only raise the issue as to whether he suspected, or had reason to suspect that what he was handling was a controlled drug of some description.

It is likely that a member of staff employed by a drug consumption room would come into possession of controlled drug at some stage (e.g. finding a controlled drug that had been abandoned or left behind by a user). Modifying the Misuse of Drugs Regulations would be a straightforward way to protect persons engaged in activities at a DCR.

A member of staff who did come into possession of a controlled drug should not return it to the user who came by it unlawfully, as this would be a clear act of supply.

## No offence of “use”

The three main United Nations conventions do not require signatories to treat, as criminal offences, the use, or the self-administration, of any controlled drug. However, signatories are free to criminalise “use” if they wish to do so. In New South Wales, an offence of “use” does exist [see **Appendix A**].

The probable reason why the United Kingdom has not made the “use” of a controlled drug unlawful is because there has been no pressing need to do so. In the vast majority of cases a person cannot use a drug without first being in possession of it. There has been a reluctance to rely on evidence of a drug trace to prove past possession: the problems of proving possession at some earlier time, are evidential rather than conceptual.

## Supply

“Supply” is not defined by the Misuse of Drugs Act 1971 beyond the fact that “supplying” includes “distributing” [section 37(1)]. Supplying is the physical transfer of the drug with the intention of enabling the recipient to use it for his/her own purposes: *Maginnis* [1987].

Drug users who require the assistance of a third party to inject a drug pose a risk for staff employed by a drug consumption room.

The following points should be noted:

- (a) It is no offence for ‘A’ to inject himself, but ‘A’ will be in unlawful possession of the drug (at least until he injects it).
- (b) If ‘B’ shares some of his heroin with ‘A’ so that the latter can use it, there will be an unlawful supply of the drug by ‘B’ to ‘A’. Drug consumption rooms must prevent that occurrence, or risk falling foul of section 8 of the Misuse of Drugs Act 1971 (permitting premises to be used for supply).
- (c) If ‘A’ was too ill to inject, and requested ‘B’ to inject him, and ‘B’ did so, then ‘B’ will be guilty of administering a “noxious thing” (heroin) contrary to section 23 of the Offences Against the Person Act 1861.
- (d) If ‘A’ loaded his own heroin into a syringe, but asked ‘B’ to inject him, it seems that ‘B’ has not supplied ‘A’ with the drug: *Cato*

[1976] 1 WLR 110, 1 All ER 260, applying *Harris* [1968] 1 W.L.R. 769.

- (e) If 'A' asked 'B' to inject him with the latter's heroin, and 'B' did so, then 'B' is guilty of the section 23 offence (OAPA 1861), *and* unlawfully supplying the drug. A manager or occupier of a drug consumption room may be guilty under section 8 (MDA 1971) if he/she knows supplying has taken place on their premises.

### *Administering a noxious thing: and manslaughter*<sup>29</sup>

#### Administering a noxious thing

Section 23 of the offences Against the Person Act 1861 provides:

...whosoever shall unlawfully and maliciously administer to, or cause to be administered to or taken by any other person any poison, or other destructive or noxious thing, so as thereby to endanger the life of such person, ... shall be guilty of an offence.

Heroin is a "noxious thing": *Cato*.<sup>30</sup>

There is no doubt that illicitly obtained heroin, mixed with water, is a "noxious thing".

Three situations need to be considered:

- i) If 'A' directly injected 'B' with heroin loaded into a syringe, 'A' has "administered" the drug, contrary to section 23. Consent is not a defence. It makes no difference if the user begged the 'helper' to inject him. Note that if the heroin belonged to 'A', then 'A' has also unlawfully supplied the drug to 'B', contrary to section 4 of the MDA 1971 (a drug trafficking offence).
- ii) On the other hand, if 'A' directly injected 'B' with the latter's own heroin then 'A' has "administered" the drug contrary to section 23, but he probably has not "supplied" him with it: *Harris* [1968] 1 W.L.R. 769.

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<sup>29</sup> This area of law is the subject of an article "Manslaughter and Drugs (again)" to be published in the *Criminal Law Review* in September 2005, written by Professor David Ormerod (Leeds University), and Rudi Fortson.

<sup>30</sup> [1976] 1 WLR 110, 1 All ER 260. Some commentators have queried that heroin of good quality is "noxious", but it is unlikely that the courts of the United Kingdom will say that *Cato* is wrong.

- iii) 'A' helped 'B' to self-inject. Example 1: 'A' prepared a syringe containing heroin, and handed the syringe to 'B', who injected himself. Example 2: 'A' holds a tourniquet around 'B's arm while the latter self-injects. This situation is considered in greater detail below.

*The judicial muddle over situation (iii).* The source of the confusion lies in a subtle, but important, legal principle illustrated by looking at two situations not connected with drug law.

- (1) 'A' and 'B' kick a man on the ground. The man's face is cut. 'A' intended to cause grievous bodily harm, but 'B' did not. In law they are "*joint principals*", but the term is misleading: actually, each is liable for their own acts and thoughts. Both perform the same act (kicking) and both cause the injuries, but their intentions differ. 'B' did not act in order to help 'A' further his criminal plan (to cause gbh). Therefore, 'A' is guilty of wounding with intent to cause grievous bodily harm, and 'B' is guilty of unlawful wounding.
- (2) If 'A' had acted with 'B', sharing an intention to cause gbh, both would be guilty of the more serious offence: they would have been "*acting in concert*" (this is a different concept).
- (3) 'A' intends to rob a bank using a gun. 'B' knows of the plan, *but he is indifferent as to whether 'A' robs the bank or not*. Nonetheless, he gives a gun to 'A' to assist the latter in his plan. That is 'B's purpose, and it makes 'B' guilty of robbery committed by 'A'.

If one applies the above to section 23 of the 1861 Act, one would expect the result to be as follows:

- The relevant acts in connection with the s.23 offence are "administering", or "cause to be administered", or "cause to be taken";
- It is not an offence to self-inject with any substance, no matter how noxious the substance is (even if it is lethal).
- A person who self-injects with illicit heroin is therefore not guilty under section 23. A person does not act unlawfully by deliberately or negligently killing himself.
- Unless two persons are applying direct pressure to the plunger of the syringe, only one person can administer the drug directly.
- Therefore the helper cannot be a 'joint principal' in the strict sense of that term. *However, in Finlay, the court seemed to say that the helper is a 'joint principal'.*

- The helper cannot be acting as a secondary party with the injector, because if the injector has not committed a crime, then the helper cannot be guilty either. *However, in Kennedy No.2, the Court said that the helper could be guilty of the s.23 offence if he is part of the process of injection.*
- A person may cause a drug to be administered or taken. But, if a person of sound mind, freely decides to inject himself, he breaks the chain of causation. *However, the courts in Rogers, and Kennedy No.2, said that the chain is not broken where the helper participates in the injection process, working together as a team.*

By what path have the courts reached this state of affairs?

In *Kennedy No.1* (1998), the court acted on the mistaken premise that it is unlawful to self-inject a controlled drug. Subsequent court decisions corrected the error: *Dalby* (1982) 74 Cr App.R.348, *Dias* [2002] 2 Cr.App.R.5., *Rogers* [2003] 1 WLR 1374, *Finlay* [2003] EWCA Crim 3868, and *Kennedy No. 2* [2005] EWCA Crim 685.

However, in *Findlay, Rogers, and Kennedy No. 2*, the Court of Appeal held that 'B' commits an offence under section 23 if he acted together with 'A'. In other words, that 'A' and 'B' acted as a team, a combined effort, to carry out an injection. This aspect is considered in greater detail in relation to the offence of manslaughter.

The decision in *Kennedy No. 2* currently represents the law, but the case may go to the House of Lords.

*Ramifications of Kennedy No.2 for DCRs.* When does liability under section 23 begin? The likely answer is that liability is confined to acts performed so closely to the moment of injection that they are to be regarded as a single act, namely, administering the drug. Grey areas remain:

- Suppose 'D' loads a syringe with heroin and places it on a table so that the injector can pick it up and use it: is 'D' liable?
- Suppose 'D' passes a syringe loaded with heroin to the injector: is it at this point that liability begins?
- If a member of staff provides a belt to the user, which the latter uses moments later as a tourniquet, has he/she participated in the "injection process"?

## Manslaughter by an unlawful and dangerous act

The issues around section 23 are germane to an analysis of a person's liability in manslaughter if death occurs due to drug intoxication. A person is liable in manslaughter if he/she carried out an unlawful and dangerous act, i.e. a criminal offence, which caused death. Note the existence of two components:

- (1) proof of the performance of an *unlawful and dangerous act*,
- (2) proof that death was caused by that act. The commission of a section 23 offence would be an unlawful and dangerous act.

Where a person *directly* injected the deceased with heroin – and the heroin caused death – then the injector is guilty of manslaughter: he committed an unlawful and dangerous act (the s.23 offence) and that act caused death. In lawyer's language, "the chain of causation has been established". It follows that a DCR must forbid one person injecting another.

But as the law currently stands, a person can be liable in manslaughter even if the deceased injected himself. A person can be liable if he assisted another in the injection process. The 'helper' would therefore be guilty of the section 23 offence, and so be liable in manslaughter if death results: *Kennedy No.2*.

There has been much criticism of this approach. If the helper truly acted 'as one' with the deceased (who self-injected), how can the 'helper' be guilty of an offence that the injector cannot commit?

The approach of the Court appears to fly in the face of another basic principle, namely, that a person of sound mind, who freely and deliberately decides to act in a particular way, is responsible for his/her own actions. A user has a choice whether or not to take a drug.<sup>31</sup>

In other words, one would expect the "the chain of causation" to be broken by the deceased's decision to inject himself. In *Dalby* (1982) 74 Cr App.R.348, the judgement of the Court seemed to endorse that approach. 'D', supplied 'P', with diconal. The crown alleged that the supply was the unlawful act that caused death. The Court of Appeal quashed 'D's conviction because 'D's act was not a direct act that caused death because:

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<sup>31</sup> There are difficult grey areas, for example the extent to which a person's decision must be 'informed'.

...the supply of drugs would itself have caused no harm unless the deceased had subsequently used the drugs in a form and quantity which was dangerous...

In subsequent decisions, including *Kennedy No.2*, the Court of Appeal has tried to manoeuvre around this difficulty by holding that if the defendant committed the section 23 offence then one element of manslaughter is established (i.e. the unlawful and dangerous act), and if death results from the act of administration, then that takes care of the second element (unlawful act causing death).

In *Finlay* [2003] EWCA Crim 3868, the Court proceeded on the basis that 'F' filled a syringe of heroin, and gave it to 'P' who died of heroin intoxication. *Finlay* was convicted of manslaughter, and his appeal against conviction was dismissed. The Court said that the test was:

Whether that act should be regarded as a matter of ordinary occurrence which would not negative the effect of the defendant's act; or something extraordinary...

The *Finlay* approach seems to boil down to this: that heroin addicts will, by reason of their addiction, follow a path of consumption from which they cannot stray, or from which they are unlikely to stray for one reason or another. Therefore, if an addict dies as a result of using a syringe containing heroin, which was given to him by a third party, it would open to a jury to say that the latter's conduct caused death. The taking of heroin in those circumstances would be "a matter of ordinary occurrence".

In *Rogers*, the deceased injected himself with heroin while R held a tourniquet around the deceased's arm. R's appeal against his conviction for manslaughter was dismissed. The Court of Appeal (Rose LJ) said:

It is artificial and unreal to separate the tourniquet from the injection. The purpose and effect of the tourniquet, plainly, was to raise a vein in which the deceased could insert the syringe. Accordingly, by applying and holding the tourniquet, the appellant was playing a part in the mechanics of the injection which caused death. It is therefore, as it seems to us, immaterial whether the deceased was committing a criminal offence.

The approach of the courts is almost to treat the user as an automaton, unable to make a free choice, and unable to exercise control over the syringe.

In *Kennedy No.2*, 'K' prepared heroin, loaded it into a syringe, and gave it to the deceased who injected himself. The deceased died of heroin intoxication. 'K' was sentenced to 5 years' imprisonment for manslaughter. The Court of Appeal dismissed the appeal. It adopted the *Rogers* approach. Lord Woolf CJ., said [emphasis added]:

To convict, the jury had to be satisfied that, when the heroin was handed to the deceased "for immediate injection", he and the deceased were both engaged in the one activity of administering the heroin. These were not necessarily to be regarded as two separate activities; ... If the jury were satisfied of this then the appellant was responsible for taking the action in concert with the deceased to enable the deceased to inject himself with the syringe of heroin which had been made ready for his immediate use.

**...the jury would have been entitled to find...that in these circumstances the appellant and the deceased were jointly engaged in administering the heroin...**

**...The point in this case is that the appellant and the deceased were carrying out a "combined operation" for which they were jointly responsible.** Their actions were similar to what happens frequently when carrying out lawful injections: one nurse may carry out certain preparatory actions (including preparing the syringe) and hand it to a colleague who inserts the needle and administers the injection, after which the other nurse may apply a plaster. In such a situation, both nurses can be regarded as administering the drug. They are working as a team. Both their actions are necessary. They are interlinked but separate parts in the overall process of administering the drug. In these circumstances... they "can be said to be jointly responsible for carrying out that act".

The decision is attracting adverse comment from academics and legal practitioners. The Court appears to be saying that liability in manslaughter is confined to acts that occurred immediately before the moment of injection. On that basis, a person who holds a tourniquet at the moment of injection is part of the injection process. But a person who merely provided the deceased with a tourniquet, and then walked away, might not be held to have taken part in the injection process.

*Implications of Kennedy No.2 for DCRs.* If a drug related death occurs within a drug consumption room, in circumstances where a member of staff unlawfully provided paraphernalia to the deceased (i.e. in contravention of section 9A, Misuse of Drugs Act 1971) there is a small risk that the employee might face a charge of manslaughter. Those working at a DCR should ensure that they do not participate in the injection process directly or indirectly. They should not provide

equipment to facilitate consumption beyond items permitted by the legislation. The fact that the member of staff was acting in good faith, and with the best of motives, are factors relevant to the exercise of discretion not to prosecute on the grounds that it would not be in the public interest to do so. However, a decision not to prosecute affords no protection from a civil action, for example in negligence.

### *Paraphernalia*

Section 9A of the Misuse of Drugs Act 1971 provides:

- (1) A person who supplies or offers to supply any article which may be used or adapted to be used (whether by itself or in combination with another article or other articles) in the administration by any person of a controlled drug to himself or another, believing that the article (or the article as adapted) is to be so used in circumstances where the administration is unlawful, is guilty of an offence.
- (2) It is not an offence under subsection (1) above to supply or offer to supply a hypodermic syringe, or any part of one.
- (3) A person who supplies or offers to supply any article which may be used to prepare a controlled drug for administration by any person to himself or another believing that the article is to be so used in circumstances where the administration is unlawful is guilty of an offence.
- (4) For the purposes of this section, any administration of a controlled drug is unlawful except-
  - (a) the administration by any person of a controlled drug to another in circumstances where the administration of the drug is not unlawful under section 4(1) of this Act, or
  - (b) the administration by any person of a controlled drug to himself in circumstances where having the controlled drug in his possession is not unlawful under section 5(1) of this Act.
- (5) In this section, references to administration by any person of a controlled drug to himself include a reference to his administering it to himself with the assistance of another.

• Section 9A creates two offences in respect of two situations:

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- (1) articles that may be used, or adapted to be used, in the **administration** of a controlled drug, and the person supplying the article believes that it will be so used;
- (2) articles used to **prepare** a controlled drug for administration/consumption.

- Note that the only point to be proved is that the article **may** be used for either of the purposes stated in s.9A, and that the person who provided the article, **believed** that it would be used for the unlawful administration of a drug.
- Note that for the purposes of s.9A, self-administration of a controlled drug is deemed to be unlawful if the user was in unlawful possession of it: s.9A(4)(b) and s.9(5).
- An offence is committed if 'A' provides 'B' with an article in the belief that 'C' will use it to a unlawfully administer a controlled drug to himself (or even to "another", for example 'D').
- No money need change hands: no considerations/value of any sort need be involved.
- The offence is summary only, that is to say it is triable only in a Magistrates' Court.

*Home Office Circular 35/2003* shows that shows that section 9A has hardly ever been used:

8. Some pharmacists and drug workers in needle exchanges supply the above items to illegal drug users for harm reduction purposes – thereby breaching section 9A and risking prosecution. We are not aware of any prosecutions because the police and the CPS have taken the view that prosecution in such cases is not in the public interest. However, the situation that drug workers are breaking the law in such cases is not satisfactory.

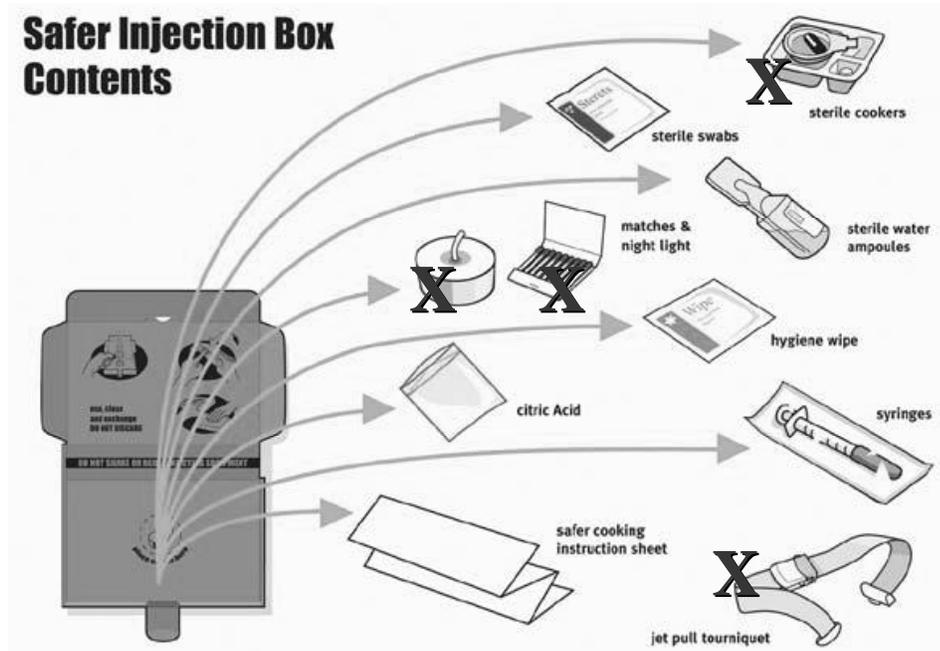
Section 9A has been tempered by the *Misuse of Drugs (Amendment)(No. 2) Regulations 2003* (SI 2003/1653). The Regulations do not amend section 9A. Instead, the regulations disapply s.9A(1) and (3) in respect of (a) a practitioner; (b) a pharmacist; or (c) "a person employed or engaged in the lawful provision of drug treatment services" if, when acting in a professional capacity, he/she supplies:

- (a) a swab;
- (b) utensils for the preparation of a controlled drug;
- (c) citric acid;
- (d) a filter;
- (e) ampoules of water for injection, only when supplied or offered for supply in accordance with the Medicines Act 1968.

*Home Office Circular 35/2003* gives the following information about the Regulations:

9. The ACMD concluded in May 2001 that particular items had significant harm reducing benefits, and recommended that the supply of **swabs**, **sterile water**, certain mixing utensils (**spoons**, **bowls**, **cups** and **dishes**) and **citric acid** should be made lawful, but only if doctors, pharmacists and drug workers supplied the items. Subsequently, in May 2003, it recommended that the supply of **filters** should also be made lawful in such cases.

In early 2003, *Lifeline* proposed supplying an injection box containing the items depicted in their leaflet (below). However, the police expressed doubts about the legality of supplying the cooker, matches, and candle (the queried items have been marked with an 'X'). (An enquiry has been made of *Lifeline* to discover whether the police removed their objections after the *Misuse of Drugs (Amendment)(No. 2) Regulations 2003* came into force: their response, confidential for the moment, is quite revealing of the problems that can be encountered by harm reduction agencies.)



Providing articles for consumption – other than those permitted by section 9A (and by the 2003 Regulations) – contravenes section 9A. That section was intended to prohibit the sale/provision of 'drug kits' – particularly kits sold for the snorting of cocaine.

It is not clear what the expression "utensils for the preparation of a controlled drug" means. The expression embraces mixing utensils, but

would a candle or a lighter (to cook heroin) come within that definition? Is the process of cooking heroin an act of “preparation”? There is a strong argument for saying that it is.

An article to be used as a tourniquet is not permitted under the Regulations. This is because the Regulations do not permit the provision of utensils for the *administration* or *consumption* of a controlled drug. The Regulations do not apply to acidifiers other than citric acid. The provision of ascorbic acid remains illegal.

Note: it is not an offence contrary to section 8 of the Misuse of Drugs Act to permit/suffer articles to be supplied in contravention of section 9A.

*Implications of section 9A for drug consumption rooms.* Managers and staff are unlikely to fall foul of section 9A if their acts are entirely passive. Few prosecutions have been brought under that provision, but interest in the offence is occasionally rekindled. Staff at a drug consumption room might not wish to take a passive role in relation to paraphernalia. Suppose a user enters the centre without the means to cook the heroin, or requires a razor blade, a straw, plastic film, aluminium foil, or an article to be used as a tourniquet.

The safest course is for the 2001 Regulations to be further amended to enable drug consumption rooms to provide a wider range of articles. The alternative solution is the complete repeal of section 9A.

In the absence of further legal protection, it would be very easy for staff to commit a section 9A offence (for example by handing over a belt, or foil, to facilitate consumption).

Note that the provision of “water for injection” continues to be problematic because its use remains regulated by the medicines legislation. The position might well change, but amendments would need to be made to the Prescription Only Medicines (Human Use) Order 1997 (the POM Order), the Medicines (Pharmacy and General Sale - Exemption) Order 1980 and the Medicines (Sale or Supply) (Miscellaneous Provisions) Regulations 1980. If a user asks a member of staff for a bottle of water, section 9A will be contravened if the employee believes that the water will be used to prepare a drug for consumption, or that it will be used for the purpose of administering the drug.

Where, in contravention of section 9A, an article has been supplied to a user who dies of heroin intoxication, it is conceivable that a conviction for

manslaughter might follow if the case of *Kennedy No.2* is correctly decided. However, the chance of a prosecution on this basis is remote. The cause of death is not the article, but the heroin. It would have to be proved (i) that the provision of the article was unlawful under section 9A, (ii) that it was a dangerous act, and (iii) that the person who provided the article, was part of the injection process as described in *Kennedy No.2*.

## *Premises*

### *Permits or suffers: managers and occupiers*

Section 8 of the MDA as originally drafted, provides:

8. A person commits an offence if, being the occupier or concerned in the management of any premises, he knowingly permits or suffers any of the following activities to take place on those premises, that is to say:

- (a) producing or attempting to produce a controlled drug in contravention of section 4(1) of this Act;
- (b) supplying or attempting to supply a controlled drug to another in contravention of section 4(1) of this Act, or offering to supply a controlled drug to another in contravention of section 4(1);
- (c) preparing opium for smoking;
- (d) smoking cannabis, cannabis resin or prepared opium.

Section 8(d) was amended by s.38 of the Criminal Justice and Police Act (CJPA) 2001 to read:

*Smoking cannabis, cannabis resin or prepared opium administering or using a controlled drug which is unlawfully in any person's possession at or immediately before the time when it is administered or used.*

Section 38 of the CJPA 2001 has not been brought into force, and it is set to be repealed as and when the relevant provision of the Drugs Act 2005 comes into force.<sup>32</sup>

Had the amended version of section 8(d) been brought into force, the effect would have been to outlaw the creation of drug consumption rooms, unless such rooms had been specifically exempted under the 2001 Misuse of Drugs Regulations.<sup>33</sup>

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<sup>32</sup> s.23, sch.1, para.6, and sch.2.

<sup>33</sup> In *Notes for Guidance*, published by the Home Office, Parliament clearly foresaw that the revised version of section 8(d) might “impinge on the legitimate harm reduction activities of those working in the care sector” [note 4]. The comfort offered to

It has been suggested by one or two commentators that the repeal of s.38, CJPA 2001, will remove the impediment to the creation of drug consumption rooms. It would be more accurate to say that the repeal of that provision removes *one* impediment, but there are others.

### Closure Orders under the Anti Social Behaviour Act 2003

Where there are reasonable grounds to suspect that conduct on premises is causing serious nuisance, or disorder, the premises may be closed under the Closure Order procedure under the Anti Social Behaviour Act 2003. The procedure may be invoked where the production, supply or use of any Class A drug causes disorder or serious public nuisance.

Whereas s.8 requires the offending activity to have actually taken place on premises,<sup>34</sup> the process for obtaining a closure order only requires reasonable suspicion on the part of the Applicant, that supply, production, or use, is occurring on premises.

The Closure Order process is civil in nature. A conviction for a drug offence is not a precondition for the making of an order.

Closure Orders are directed against premises – not persons.

The Home Office *Notes for Guidance* give the following examples of circumstances that might be regarded as “serious”:

- intimidating and threatening behaviour towards residents;
- a significant increase in crime in the immediate area surrounding the accommodation;
- the presence or discharge of a firearm in or adjacent to the premises;
- significant problems with prostitution;
- sexual acts being committed in public;
- consistent need to collect and dispose of drugs paraphernalia and other dangerous items;
- violent offences and crime being committed on or in the vicinity of the premises;

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practitioners in the field of harm reduction was that “police officers must use discretion based on the public interest test, to determine whether charging the suspect is appropriate and proportionate” [note 7].

<sup>34</sup> *R v Auguste* [2003] EWCA Crim 3929.

- number counts of volume of people entering and leaving the premises over a 24-hour period and the resultant disruption they cause to residents;
- noise – constant/intrusive noise – excessive noise at all hours associated with visitors to the property.

The following should be noted:

- The decision to issue a closure order is that of a police officer of the rank of Superintendent or above.
- The officer must act in consultation with the local authority.
- There must be reasonable suspicion that production, supply, or use, has occurred at the premises within the previous three months.
- There must be reasonable grounds to believe that the premises is associated with disorder or serious nuisance.
- Reasonable steps must be taken to identify interested parties.

Although it is an officer who serves a *Closure Order Notice*, it is a Magistrates' Court that makes a Closure Order.

- The Closure Order may be made as soon as 48 hours following service of notice.
- The appeal is to the Crown Court. The time for appealing is 21 days from the date the order is made.
- Premises may remain closed for as long as necessary to remedy the social problem that justifies making the order.

A check list for officers, and a flow chart have been provided by the Home Office, copies of which are appended to this paper [**Appendix B and C**].<sup>35</sup>

It would seem that a civilian has no power to initiate closure proceedings under the 2003 Act, but one approach would be for persons to petition both the local authority and the chief constable to take action against a drug consumption room. It is unlikely that a civil action would succeed to compel the relevant public authorities to initiate closure proceedings, provided those authorities acted reasonably in taking the decision not to intervene.

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<sup>35</sup> “*Closure of Premises used in connection with the production, supply or use of Class A drugs and associated with the occurrence of disorder or serious nuisance. Notes of Guidance.*”

The preferred option would be for a drug consumption room to be licensed by the appropriate government department, and given the protection it needs by amending the relevant regulations made under the Misuse of Drugs Act 1971, and under the Medicines Act 1968.

### **What can be done?**

Many of these issues could be resolved by giving DCRs statutory protection, but this would require primary legislation (at least in relation to offences other than under the MDA 1971 and the Medicines Act 1968).

This is the position in Australia. Note section 36O of the Drug Misuse and Trafficking Act 1985:

#### *36O Exemption from criminal liability for persons engaged in conduct of licensed injecting centre*

Despite any other provision of this Act or of any other Act or law (other than a provision prescribed by the regulations):

- (a) it is not unlawful for a person to engage, participate or otherwise be involved in the conduct of a licensed injecting centre, and
- (b) in particular, a person who is engaged, participates or is otherwise involved in the conduct of a licensed injecting centre does not commit an offence under section 14 or 19, or any other offence prescribed by the regulations, just because of that fact.

### **Negligence**

There is no reason to suppose that the courts of civil jurisdiction would develop and apply principles unique to drug consumption rooms (either for or against them). Those managing and controlling a drug consumption room would need to be mindful of the areas of operation that might reasonably give rise to legitimate complaint.

It is no answer for a drug consumption room to say that in seeking to address one set of social problems, it is entitled to be protected from liability by the common law if its actions create another (albeit less serious) set of problems, or loss and damage has been caused. Without statutory intervention, a drug consumption room will be subject to the legal obligations, duties, and requirements that affect other service providers.

Those who operate a drug consumption room will have to meet health and safety requirements. Employers will be required to exercise reasonable skill and care in protecting its employees from loss or injury, whilst (perhaps) being vicariously liable for acts performed by them in the ordinary course of their employment.

It will be seen that the MSIC is protected by statute (requiring primary legislation). Section 36P of the Australian Drug Misuse and Trafficking Act 1985 provides:

*36P Exemption from civil liability in connection with conduct of licensed injecting centre*

- (1) Anything done or omitted to be done in connection with the conduct of a licensed injecting centre does not subject:
  - (a) the person by whom that thing was done or omitted, or
  - (b) any other person (including the licensee, the State and any Minister of the Crown in right of the State),to any action, liability, claim or demand if the thing was done or omitted to be done in good faith for the purpose of executing this Part, and was not done or omitted to be done in a reckless or grossly negligent manner.
- (2) This section does not affect any rights or obligations as between a member of the staff of a licensed injecting centre and his or her employer.

## **The risk of an adverse judicial determination**

Some commentators draw parallels between drug consumption rooms and needle exchange centres in terms of their rights, duties, and liabilities under the law. But there are obvious significant differences between the two services.

Although the experience of needle exchange centres, and the experience of existing drug consumption rooms, will be instructive, persons who contemplate setting up a drug consumption room in the United Kingdom would be well-advised to draw up proposals and policies mindful of:

- (i) the law as it exists in the United Kingdom;
- (ii) the policy considerations that appear to underpin the relevant legal principles; and

- (iii) the services that already exist (if any) in respect of the target population.

The commentary, "*Unsupervised Fixing Rooms, Supervised Injectable Maintenance Clinics - Understanding The Difference*" [Strang and Fortson, 100 *BMJ* Volume 328, 10 January 2004] attracted much interest, but correspondents did not adequately address one passage:

For the open access supervised injecting centre, there are major operational issues. Should the attendee be prohibited from choosing certain drug mixtures, doses, or sites of injecting considered too dangerous—for example, injecting barbiturates or temazepam, or ground-up tablets of methadone, Diconal (dipipanone/cyclizine) or Ritalin (methylphenidate), or injecting dangerous doses, or injecting in femoral or neck veins? Would there be a lower age limit? When deaths occur (inevitable, eventually), where will medico-legal liability lie? Both action and inaction may leave the doctor and organisation liable. And what of charges (already made) of aiding and abetting, and even fostering more frequent and more excessive drug use? When dealing occurs (inevitable, to some extent), will agencies and staff be open to prosecution, as with the imprisoned staff from Winter Comfort day centre? These obstacles may not be insuperable, but they cannot just be ignored.

The case of *Kennedy No.2* shows that the passage cited above is not idle speculation. Without legal protection, a drug consumption room by reason of the fact that it operates on the borders of what is legally permissible, will routinely face medico-legal dilemmas. For example, an attendee might be competently advised not to use certain drug mixtures, or doses, and warned against using sites of injecting that are considered to be too dangerous for the attendee to use. Presumably such advice would be given on a case-by-case basis, and shortly before the moment of injection. The practitioner who gives advice on the basis that one dangerous method of administration is preferable to an even more dangerous method, takes the risk that his actions might be construed as encouraging/assisting the attendee to carry out that dangerous act. The practitioner's conduct might be unlawful if he/she involves himself too closely with the injection process,<sup>36</sup> and so commits the section 23 offence (i.e. contrary to the Offences Against the Person Act 1861). Such a result is unlikely, but a practitioner would be well advised to make it clear that the action of self-administration is not condoned by the

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<sup>36</sup> See *Kennedy No.2* (above).

DCR, that the decision to inject (or to inject in a particular way) is that of the attendee.

Better still, the DCR should press for some form of statutory protection (which would require primary legislation) against being held criminally liable for acts carried out in good faith in the course of providing services at the DCR.

### **Police powers and protocols**

The police, and the local authority, will wish to ensure that a drug consumption room does not give rise to disorder, or a serious nuisance, or import into the area social problems on a scale that did not exist before the drug consumption room opened. There is some anecdotal information that police officers have occasionally targeted persons who have left a drug consumption room, or who were about to enter one. Tensions between the police, and a drug consumption room, are best dealt with by way of protocols that represent the consensus of as many relevant interested parties as possible. Various statutory bodies (not just the police) are empowered to call for the production of records kept by an organisation or facility. Although records may speak against the author, the absence of records can be equally damaging: see the *Winter Comfort* case.

In the absence of specific legislative provision, rules of law relating to data, confidentiality, and professional privilege, will differ little from those applicable to needle exchange centres, or other agencies, that provide a public service at which controlled drugs or medicinal products are handled, or are at least involved.

## Appendix A

### Drug Misuse and Trafficking Act 1985 No 226

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#### 36E Licence

- (1) The responsible authorities may issue a licence authorising the holder of the licence to conduct specified premises as an injecting centre.
- (2) Nothing in this Part entitles a person to be issued with a licence, and the responsible authorities may refuse an application for a licence if the requirements of section 36F are not satisfied or for any other reason.

### Drug Misuse and Trafficking Act 1985 No 226

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#### 36F Restrictions on issue of licence

- (1) A licence for the conduct of premises as an injecting centre must not be issued unless the responsible authorities are of the opinion:
  - (a) that the internal management protocols for the proposed centre have been finalised and are of a satisfactory standard, and
  - (b) that there is a sufficient level of acceptance, at community and local government level, for the establishment of an injecting centre at the premises, and
  - (c) that the premises are suitable for use as an injecting centre, having regard to all relevant matters including the following:
    - (i) public health and safety,
    - (ii) the visibility of the premises from the street,
    - (iii) the proximity of the premises to schools, child care centres and community centres,
    - (iv) any matters prescribed by the regulations for the purposes of this section.
- (2) If a community drug action plan is in force in relation to the area within which the premises of the proposed injecting centre are situated, the responsible authorities must have regard to that plan in forming an opinion as to the matters referred to in subsection (1) (b) and (c).

(3) Without limiting subsection (1), a licence for the conduct of premises as an injecting centre must not be issued unless the responsible authorities are of the opinion:

(a) that any building work that is carried out for the purposes of the centre will be carried out in accordance with the *Building Code of Australia*, and

(b) that any building that is used for the purposes of the centre will comply with the *Building Code of Australia*.

(4) In subsection (3), **building**, **Building Code of Australia** and **building work** have the same meanings as they have in the *Environmental Planning and Assessment Act 1979*.

## **Drug Misuse and Trafficking Act 1985 No 226**

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### **36G Duration of licence**

(1) Unless sooner surrendered or revoked, a licence has effect for the whole of the trial period.

(2) The holder of a licence may, after consultation with the responsible authorities or their representatives, surrender the licence.

## **Drug Misuse and Trafficking Act 1985 No 226**

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### **36H Conditions of licences generally**

(1) A licence is subject to such conditions as may be imposed from time to time by the responsible authorities, either in the licence or in a separate order in writing served on the holder of the licence.

(2) Conditions of the kind referred to in subsection (1) may not be imposed without prior consultation with the holder or proposed holder of the licence.

(3) A licence is also subject to such conditions as are imposed by or under this Part or the regulations.

## **Drug Misuse and Trafficking Act 1985 No 226**

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### **36I Statutory conditions of licences**

The following provisions are conditions of a licence for an injecting centre:

- (a) No child is to be admitted to that part of the centre that is used for the purpose of the administration of prescribed drugs.
- (b) The centre's internal management protocols are to be observed.

## **Drug Misuse and Trafficking Act 1985 No 226**

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### **36J Contraventions**

(1) A contravention of this Division or the regulations in relation to a licensed injecting centre, or of the licence conditions for a licensed injecting centre, may be dealt with:

(a) by one or more of the following:

- (i) a warning or reprimand administered in writing by the responsible authorities,
- (ii) a fine (not exceeding an amount equal to 100 penalty units) imposed by the responsible authorities,
- (iii) suspension of the licence by the responsible authorities for a specified period or until further notice, or

(b) by revocation of the licence by the responsible authorities.

(2) If the contravention also gives rise to an offence:

(a) the fact that action has been taken under this section in relation to the contravention does not prevent a penalty from being imposed for the offence, and

(b) the fact that a penalty has been imposed for the offence does not prevent action from being taken under this section in relation to the contravention.

(3) A fine imposed under this section is payable to either responsible authority within the period specified by the responsible authorities, and is to be paid into the Consolidated Fund.

(4) If a licensee fails to pay a fine imposed under this section (in whole or in part), the responsible authorities may suspend or revoke the licence.

- (5) Nothing in this section prevents the responsible authorities from amending or imposing a condition as a consequence of a contravention referred to in subsection (1).
- (6) The responsible authorities are authorised to suspend or revoke a licence for the purposes of this section.
- (7) A contravention referred to in subsection (1):
- (a) does not limit the operation of section 36O, except to the extent that the contravention gives rise to an offence under the regulations made for the purposes of this Part, and
  - (b) does not limit the operation of section 36P.
- (8) A contravention relating to the admission of a child to a licensed injecting centre is not committed if the licensee establishes that, having regard to the relevant provisions of the centre's internal management protocols, it was not apparent to the centre's staff that the person concerned was a child.

## Drug Misuse and Trafficking Act 1985 No 226

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### 36K Reviews

The responsible authorities are to arrange for the ongoing or periodical review of any licensed injecting centre.

## Drug Misuse and Trafficking Act 1985 No 226

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### 36N Exemption from criminal liability for users of licensed injecting centre

- (1) In this section:
- exempt quantity**, in relation to a prescribed drug, means:
- (a) in the case of a prohibited drug, a small quantity of the drug (subject to paragraph (b)), or
  - (b) in any case, such quantity of the drug as is prescribed by the regulations.
- (2) Despite any other provision of this Act or of any other Act or law (other than a provision prescribed by the regulations):

- (a) it is not unlawful for a person at a licensed injecting centre:
- (i) to be in possession of (otherwise than for supply) no more than an exempt quantity of a prescribed drug, or
  - (ii) to be in possession of an item of equipment for use in the administration of a prescribed drug, or
  - (iii) to administer or attempt to administer to himself or herself no more than an exempt quantity of a prescribed drug, and
- (b) in particular, a person at a licensed injecting centre:
- (i) who has in his or her possession (otherwise than for supply) no more than an exempt quantity of a prescribed drug, or
  - (ii) who has in his or her possession an item of equipment for use in the administration of a prescribed drug, or
  - (iii) who administers or attempts to administer to himself or herself no more than an exempt quantity of a prescribed drug,
- does not commit an offence under section 10, 11 or 12, or any other offence prescribed by the regulations, just because of that fact.
- (3) Subsection (2) does not affect the operation of:
- (a) the conditions of any recognizance to which a person is subject (whether under the Crimes Act 1900 or otherwise), or
  - (b) any bail conditions to which a person is subject under the Bail Act 1978, or
  - (c) the conditions of any program to which a person is subject under the Drug Court Act 1998.
- (4) Nothing in this section prevents a police officer from exercising a discretion not to charge a person with an offence under section 10 or 11:
- (a) in respect of the possession of a prescribed drug, or
  - (b) in respect of the possession of an item of equipment for use in the administration of a prescribed drug,
- while the person is travelling to or from, or is in the vicinity of, a licensed injecting centre.

(5) The reference in subsection (4) to a discretion includes a reference to a discretion referred to in any guidelines applicable to police discretions.

## **Drug Misuse and Trafficking Act 1985 No 226**

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### **36O Exemption from criminal liability for persons engaged in conduct of licensed injecting centre**

Despite any other provision of this Act or of any other Act or law (other than a provision prescribed by the regulations):

- (a) it is not unlawful for a person to engage, participate or otherwise be involved in the conduct of a licensed injecting centre, and
- (b) in particular, a person who is engaged, participates or is otherwise involved in the conduct of a licensed injecting centre does not commit an offence under section 14 or 19, or any other offence prescribed by the regulations, just because of that fact.

## **Drug Misuse and Trafficking Act 1985 No 226**

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### **36P Exemption from civil liability in connection with conduct of licensed injecting centre**

(1) Anything done or omitted to be done in connection with the conduct of a licensed injecting centre does not subject:

(a) the person by whom that thing was done or omitted, or

(b) any other person (including the licensee, the State and any Minister of the Crown in right of the State), to any action, liability, claim or demand if the thing was done or omitted to be done in good faith for the purpose of executing this Part, and was not done or omitted to be done in a reckless or grossly negligent manner.

(2) This section does not affect any rights or obligations as between a member of the staff of a licensed injecting centre and his or her employer.

## Appendix B

### **Closure Notice Approval Check List for Senior Officer [Annex H]**

- Is there serious nuisance from the premises?
- Is there suspicion of production use or supply of Class A drugs?
- Has evidence of this been appropriately collated?
- Is this within 3 months of the authorisation of the Closure Notice (today)?
- Has the Local Authority been consulted?
- Has this involved an exchange of information and have their views been taken into account where desirable?
- Have those who live, control, own or have responsibility or an interest in the premises been identified?
- Have Notices been prepared to be served upon them?
- Have other options been considered or tried where possible?
- Has a Magistrates Court Hearing been secured within 48 hours of the intended date and time of service?
- Does the Closure Notice contain the information required by the Act?
- Notice of the application for a Closure Order
- State the date, time and place where this will be heard
- Inform all persons that access to the premises by those other than the habitual resident or owner is prohibited
- Explain that access by any other persons is considered an offence
- Detail the effects of a Closure Order if issued by the court
- Provide information on how to contact advice providers such as housing or legal advisors or organisations
- Have CDRP/DAT/LSP partners been notified as appropriate?
- Has a risk assessment been made against the premises?
- Has appropriate back up therefore been provided and other policing tactics to be used alongside this action been considered?
- Has the nature of the premises and possible vulnerable persons or children been considered?
- Have appropriate services therefore been of the potential demand upon them by these groups and drug users?
- Has the social good of closure been considered?
- Have arrangements been made for the secure sealing of the premises and the isolation of utilities?
- Have arrest referral services been informed?

Has the Secretary of State granted any exemptions to types of premises?

If so does the premises fall within that exemption?

Have appropriate structures been put in place to ensure witnesses can be contacted for the case and will be kept informed of developments?

Is there a plan to follow up the closure with renewed efforts to combat drugs and crime in the area?

*Setting up a drug consumption room*

## Appendix C

