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15 October 2024
Director-General of Health
Minister of Health
Associate Minister of Health
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133 Molesworth Street
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Copy to:
Parliamentary Leaders (by signature courier)
All New Zealand Councils (by signature courier)
All members of Parliament (by email only)

Dear all

OPEN LETTER AND POSSIBLE LEGAL ACTION – FLUORIDATION OF DRINKING WATER IN NEW ZEALAND

1.1. I am writing to you concerning the directives which the Director-General of Health (**Director-General**) issued to 14 Council in July 2022 under the Health Act 1956 (**the Act**) to fluoridate the drinking water (**the directives**) which was part of the former Government's Three Waters Reform Programme which the current Government is now unwinding.

1.2. Part of the Three Waters Reform included:

(a) the repealing Part 2A of the Act, which covered Drinking Water and the introduction of Part 5A of the Act, which set out the provisions for Fluoridation of Drinking Water.; and
(b) the passing of the stand-alone legislation in the form of the Water Service Act 2021.

1.3. The current Government's unwinding of the Three Water Reform does not consider the introduction of Part 5A of the Act and the Fluoridation of Drinking Water.

EXECUTIVE SUMMARY

1.4. By way of executive summary, it is contended that the directives are open to challenge due to:

(c) Predetermined Decision: the former Director-General's decision to issue the directives was predetermined, as is evidenced by his statements to the media eight months prior to issuing the directives;

(d) Statutory Duty: the Director-General must consider the matters set out in section 116E of the Act prior to exercising the statutory discretion to issue a directive or not. The Directive-General failed to satisfy the statutory duty when considering the matters required by the Act; and

(e) Administrative Law Principles: Administrative law principles require the Director-General to act reasonably, in accordance with the law, fairly in accordance with natural justice principles, when exercising a statutory power of decision making. The Directive-General failed to comply with administrative law principles when exercising the statutory power of decision making.

1.5. Accordingly, the decision of the Director-General to issue the directives is open to legal challenge. The Courts have the power to issue a writ of mandamus to compel the Director-General to perform duties in relation to the exercise, refusal to exercise, or proposed or purported exercise of a statutory power such as decision making.

1.6. However, to avoid taking up the Court's valuable time, I suggest that the incumbent Director-General pause the enforcement of the directives:

(a) Proper Assessment: undertake a proper assessment under section 116E of the Act by complying with the statutory duty and administrative law principles;
(b) Outcome of Current High Court Case: until for the outcome of the Crown's appeal of the Bill of Rights case concerning the directives.

2. PROPER ASSESSMENT

2.1. Section 116E of the Act states that the Director-General "must" (imposing a rule and duty on the Director General) consider the following two criterion:

(a) Criterion 1: Scientific Evidence: the scientific evidence on the effectiveness of adding fluoride to drinking water in reducing the prevalence and severity of dental decay; and
(b) Criterion 2: Benefits vs Costs: whether the benefits of adding fluoride to the drinking water outweigh the financial costs, taking into account:
    (ii) the state or likely state of the oral health of a population group or community where the local authority supply is situated; and
    (iii) the number of people who are reasonably likely to receive drinking water from the local authority supply; and

(iv) the likely financial cost and savings of adding fluoride to the drinking water, including any additional financial costs of ongoing management and monitoring.

2.2. When assessing the second criterion, the Director-General may consider any relevant factors.

2.3. The Director-General must consider both sides of the argument, and that must include the significant and landmark negative research published recently, as well as the reasons for significant judicial decisions against fluoridation elsewhere. As an aside, as a practising medical doctor, the Director-General is supposed to `First Do No Harm' and obtain informed consent for medical decisions, and the Medical Council of New Zealand is mandated by the HPCAA to ensure all its doctors uphold medical ethics.

2.4. If the Director-General undertakes a proper assessment of the matters required by section 116E of the Act, the Director-General must consider updated scientific evidence. This included the updated 2024 Cochrane Collaboration, given that the 2015 Cochrane Collaboration was one of the three documents the Director-General considered prior to issuing the directives.

2.5. The 2024 Cochrane Collaboration found, amongst other things, that the:

(a) Minimal Benefits: benefits of fluoride in water supplies may be smaller than they were before the widespread addition of fluoride to toothpaste.

(b) Uncertainties: while adding fluoride to water supplies "may" lead to slightly less tooth decay in children's baby teeth, the researchers could not be sure whether adding fluoride to water reduced tooth decay in children's permanent teeth.

(c) Dental Fluorosis: in the latest version of the review, the researchers found that adding fluoride to water supplies increases the number of people with dental fluorosis. If water contains 0.7 mg/L of fluoride, about 12% of people may have dental fluorosis that causes them to be bothered about how their teeth look, and about 40% of people may have dental fluorosis of any level.

2.6. Along with taking into account the current research and science, the Director-General would be ill advised to ignore the recent U.S Federal Court case where:

(a) Unreasonable Potential Risk to Children: the Court ordered the U.S. Environmental Protection Agency to strengthen regulations for fluoride in drinking water, saying the compound poses an unreasonable potential risk to human health and the environment at levels that are currently typical nationwide.

As a side note, in April 2015 the U.S. Department of Health and Human Services Agency revised the fluoride level believed to reduce dental decay and recommended that water

systems practicing fluoridation adjust their fluoride content to 0.7 mg/l (parts per million), as opposed to the previous temperature-dependent optimal levels ranging from 0.7 mg/l to 1.2 mg/l.

The recommended levels in New Zealand are between .7 mg/l to 1.2 mg/l. As recently as last week, the Otago Daily Time reported that fluoridation had been paused for at least two weeks after it the levels were found to be too high.

(b) **Reduced IQ**: the Judge found that the applicant had established that fluoride posed an unreasonable risk of harm sufficient to require a regulatory response by the EPA under the Toxic Substances Control Act and stated that:

> *"The scientific literature in the record provides a high level of certainty that a hazard is present; fluoride is associated with reduced IQ*[1]*."*

2.7. The Office of the Prime Minister's Chief Science Advisor Report, `*EVIDENCE SUMMARY: Fluoride in our drinking water: An update on the evidence*'[2], dated June 2021 ("**2021 Office of the Prime Minister Report**") states that:

> *"Recent studies continue to show that at very high levels and with chronic exposure, fluoride could potentially have negative neurodevelopmental and cognitive impacts. However, this is not a concern at levels used in fluoridation of water supplies in Aotearoa New Zealand."*

2.8. This court action was a result of the recently published National Toxicology Program's 2023 review of multiple studies, which showed conclusively that fluoridation chemicals added to water are neurotoxic. They cause damage to the structure and function of developing brains, though the scientific semantics of published research require the use of terms such as "risk of reduced IQ" or "may cause brain damage". The Level 1 strength of evidence is clear though: water fluoridation causes brain damage.

2.9. In performing the statutory duties under the Act, the Director-General would also need to consider the whether the benefits outweigh the financial costs in 2024 given the sharp increase in the costs, considering the latest reviews (Cochrane, LOTUS and CATFISH) show a much-reduced benefit.

3. PURPOSE OF THE ACT

3.1. Statutory decision-making powers are limited in a democracy, and any such discretion must be exercised in a way that is consistent with the purpose of the statute. In addition, decision

[1] https://www.dpmc.govt.nz/sites/default/files/2022-04/PMCSA-21-05-3_OPMCSA-Fluoridation-Webpage-11102021.pdf
[2] https://www.dpmc.govt.nz/sites/default/files/2022-04/PMCSA-21-05-3_OPMCSA-Fluoridation-Webpage-11102021.pdf

making powers can also be limited by the common law, the need to exercise the power reasonably or undertake the processes to meet natural justice requirements.

3.2. The Act does not contain a purposes or objects section. Accordingly, the Act must be read as a whole, and its history and other wider factors be considered. The following is applicable to the Director-General's decision:

(a) Administration of the Ministry of Health (Part 1 of the Act) states that the Ministry shall have the function of improving, promoting, and protection public health.

(b) Powers and Duties of Local Authorities (Part 2 of the Act) places a duty on every local authority to improve, promote, and protect public health within its district.

(c) Fluoridation of Drinking Water (Part 5A) states that the purpose is to enable the Director-General to direct a local authority to add fluoride or not to add fluoride to drinking water supplied through its local authority supply; and require the local authority to comply with the direction.

4. FLUORIDATION OF DRINKING WATER

4.1. The MOH's rationale for the fluoridation of our drinking water is tooth decay and that it is an important contributor to health equity and that:

> *"[i]t provides the greatest benefits for Māori, Pacific peoples, children, and communities with poorer oral health outcomes[3]."*

4.2. When Part 2A of the Act, Drinking Water, was repealed and Part 5A, Fluoridation of Water, was introduced in 2021, the Director-General had to decide whether to:

(a) No Directive: not issue a directive to add fluoride to the drinking water as is the case in many other countries around the world and implement a target oral health programme They could implement a target oral health programme such as the Scottish school toothbrushing scheme, CHILDSMILE. The National Health Service for Scotland implemented such a programme 23 years ago which has bought child tooth decay rates below New Zealand rates and saves millions in dental health costs. Importantly, it has halved the number of general anaesthetics required for severe tooth decay in children. There are now other successful programmes around the world modelled on the successful Scottish initiative.; or

(b) Issue the Directive: issue a directive to add fluoride to the drinking water and mass medicate all New Zealanders regardless of their oral health risk and when the University of Auckland's longitudinal study, `Growing Up in New Zealand', foods most associated with tooth decay in New Zealand children are white bread, fruit juice, refined breakfast

[3] https://www.health.govt.nz/strategies-initiatives/programmes-and-initiatives/oral-health/community-water-fluoridation-policy

cereals and sugar sweetened soft drinks[4]. The presence of fluoride in the water does not mean that risk children will drink the water. A 2019 University of Auckland study of 27,3333 children living in Auckland and Northland in 2014 – 2015 and found that children had one or more decaying, missing or filled tooth by the time they started school and recommend tax and health warning to reduce the consumption of sugary drinks, oral health promotion in at risk communities along with fluoridation[5].

4.3. Mass medication of our drinking water is the most intrusive intervention of the two options. Given the seriousness of the intervention, the courts are more likely to closely assess whether the Director-General complied with the statutory framework and the applicable administrative law principles when exercising the power of public decision making.

5. DIRECTOR-GENERAL'S ANAYLSIS OF THE EVIDENCE

5.1. The Director-General sent a letter to the affected councils in May 2022, `*Community Water Fluoridation Next Steps Letter*' (**Next Steps Letter**) requesting the estimated financial cost of adding fluoride to the drinking water, including any additional costs of ongoing management and monitoring[6]. Annexure 1 of the Next Steps letter records that the evidence and analysis for the scientific evidence criterion that the Director-General considered for

Criterion 1: Scientific Evidence

5.2. When consider evidence to satisfy Criterion 1: Scientific Evidence of the statutory test, the Director-General considered the following documents:

(a) The 2021 Office of the Prime Minister Report (which is noted at paragraphs 3.7 above in which they acknowledge that recent studies continue to show that at very high levels and with chronic exposure, fluoride could potentially have negative neurodevelopmental and cognitive impacts)

(b) Health effects of water fluoridation: A review of the scientific evidence (August 2014) Office of the Prime Ministers Chief Science Advisor and Royal Society of New Zealand Te Aparangi

(c) Water fluoridation to prevent tooth decay | Cochrane Collaboration (June 2015)

5.3. The analysis of the above documents is set out in Appendix 1 and recorded as follows:

> *"The sources of evidence referred to above are reviews that examine significant bodies of research over a long time period on the safety and effectiveness of community water*

[4] https://www.growingup.co.nz/news/the-key-culprits-in-tooth-decay-in-new-zealand-children

[5] https://www.auckland.ac.nz/en/news/2019/04/12/two-in-five-kids-have-teeth-cavities-by-age-five.html

[6] https://fyi.org.nz/request/19839-local-goverment-implementation-of-water-fluoridation

fluoridation at reducing dental decay. The evidence indicates the provision of community water fluoridation at a level of 0.7-1 mg/L significantly reduces the prevalence and severity of dental decay. While the review's outcome is not dependent on any specific study, findings from individual studies cited in the reviews include:

- *data from the 2009 New Zealand Oral Health Survey showed that children and adolescents from un-fluoridated areas had 1.7 times as many decayed, missing or filled teeth (when adjusted for sex, ethnic group and socio-economic status) than those from fluoridated areas*
- *an Australian review undertaken in 2017 found that fluoridation reduces tooth decay in children and adolescents by 26 to 44 percent, and in adults by 27 percent*
- *the UK NHS/York review calculated that in the United Kingdom the "number needed to treat" was six (ie, a median of six people needed to receive community water fluoridation for one additional person to be caries- free).*

On this basis, the provision of community water fluoridation at a level of 0.7-1 mg/L in New Plymouth would significantly reduce the prevalence and severity of dental decay within these areas. Fluoridation at these levels is considered to be safe and effective at reducing decay."

5.4. The only independent report is the Cochrane Collaboration which provides updates and maintain a systematic review of community water fluoridation that reflects contemporary evidence. The latest Cochrane Collaboration is discussed above. The stated objectives are to evaluate the effects of water fluoridation (artificial or natural) on the prevention of dental caries and dental fluorosis, and they use an adaptation of the Cochrane 'Risk of bias' tool to assess risk of bias in the included studies. The 2015 Cochrane Collaboration[7] main results were as follows:

"A total of 155 studies met the inclusion criteria; 107 studies provided sufficient data for quantitative synthesis.

The results from the caries severity data indicate that the initiation of water fluoridation results in reductions in dmft [decayed, missing and filled teeth] of 1.81 (95% CI 1.31 to 2.31; 9 studies at high risk of bias, 44,268 participants) and in DMFT of 1.16 (95% CI 0.72 to 1.61; 10 studies at high risk of bias, 78,764 participants). This translates to a 35% reduction in dmft and a 26% reduction in DMFT compared to the median control group mean values. There were also increases in the percentage of caries free children of 15% (95% CI 11% to 19%; 10 studies, 39,966 participants) in deciduous dentition and 14% (95% CI 5% to 23%; 8 studies, 53,538 participants) in permanent dentition. ***The majority***

[7] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010856.pub2/full

of studies (71%) were conducted prior to 1975 and the widespread introduction of the use of fluoride toothpaste.
There is insufficient information to determine whether initiation of a water fluoridation programme results in a change in disparities in caries across socioeconomic status (SES) levels.

There is insufficient information to determine the effect of stopping water fluoridation programmes on caries levels.

No studies that aimed to determine the effectiveness of water fluoridation for preventing caries in adults met the review's inclusion criteria.

With regard to dental fluorosis, we estimated that for a fluoride level of 0.7 ppm the percentage of participants with fluorosis of aesthetic concern was approximately 12% (95% CI 8% to 17%; 40 studies, 59,630 participants). This increases to 40% (95% CI 35% to 44%) when considering fluorosis of any level (detected under highly controlled, clinical conditions; 90 studies, 180,530 participants). Over 97% of the studies were at high risk of bias and there was substantial between-study variation."

5.5. The Authors' Concluded:

"There is very little contemporary evidence, meeting the review's inclusion criteria, that has evaluated the effectiveness of water fluoridation for the prevention of caries.

The available data come predominantly from studies conducted prior to 1975, and indicate that water fluoridation is effective at reducing caries levels in both deciduous and permanent dentition in children. Our confidence in the size of the effect estimates is limited by the observational nature of the study designs, the high risk of bias within the studies and, importantly, the applicability of the evidence to current lifestyles. The decision to implement a water fluoridation programme relies upon an understanding of the population's oral health behaviour (e.g. use of fluoride toothpaste), the availability and uptake of other caries prevention strategies, their diet and consumption of tap water and the movement/migration of the population. There is insufficient evidence to determine whether water fluoridation results in a change in disparities in caries levels across SES. We did not identify any evidence, meeting the review's inclusion criteria, to determine the effectiveness of water fluoridation for preventing caries in adults.

There is insufficient information to determine the effect on caries levels of stopping water fluoridation programmes.

There is a significant association between dental fluorosis (of aesthetic concern or all levels of dental fluorosis) and fluoride level. The evidence is limited due to high risk of bias within the studies and substantial between-study variation".

Criterion 2: Benefits vs Costs:

5.6. When consider evidence to satisfy Criterion 2: Benefits vs Costs of the statutory test, the Director-General considered the following documents:

(a) data on Age 5 and Year 8 oral health outcomes from the Community Oral Health Service (Ministry of Health)
(b) data from the New Zealand Health Survey: Oral Health (New Zealand Health Survey | Ministry of Health NZ)
(c) Oral Health Survey Report (Our Oral Health: Key findings of the 2009 New Zealand Oral Health Survey | Ministry of Health NZ)
(d) New Zealand Index of Deprivation (NZDep) (Socioeconomic deprivation profile | ehinz).

5.7. Oral Health Survey Report includes the following disclaimer:

"People living in areas with fluoridated water

***Although this survey was not designed as an in-depth water fluoridation study**, data were examined for any protective effect of fluoride against dental decay, as well as for prevalence and severity of dental fluorosis (a possible side-effect of having too much fluoride during early tooth development). Overall, children and adults living in fluoridated areas had significantly lower lifetime experience of dental decay (ie, lower dmft/DMFT) than those in non-fluoridated areas. There was a very low overall prevalence of moderate fluorosis (about 2%; no severe fluorosis was found), and no significant difference in the prevalence of moderate fluorosis (or any of the milder forms of fluorosis) between people living in fluoridated and non-fluoridated areas.*

These findings support international evidence that water fluoridation has oral health benefits for both adults and children. In addition, these findings should provide reassurance that moderate fluorosis is very rare in New Zealand, and that the prevalence of any level of fluorosis was not significantly different for people living in fluoridated and non-fluoridated areas.

5.8. The Oral Health Survey Report also refers to studies which found that the:

"Key ways of preventing dental decay include brushing teeth twice a day with fluoride toothpaste to remove dental plaque, limiting the consumption of sugary food and drinks, and drinking fluoridated water"

6. ADMINISTRATIVE LAW PRINCIPLES

6.1. Administrative law principles require the Director-General to act reasonably, in accordance with the law, fairly in accordance with natural justice principles when exercising a statutory power of decision making.

6.2. If the Director-General does not adhere to the administrative law principles, the decision can be challenged by way of judicial review seeking a Writ of Mandamus. The Writ of Mandamus compels the performance of duties of a public nature in relation to the exercise, refusal to exercise, or proposed or purported exercise of a statutory power.

Unlawfulness

6.3. The statutory power under the Act clearly sets out the process that the Director-General must consider prior to making the decision to issue a directive or not to fluoridate the drinking water. While the Director-General can exercise judgement, the Director-General must believe on reasonable grounds that:

(a) the scientific evidence supports adding fluoride to drinking water in reducing the prevalence and severity of dental decay; and
(b) whether the benefits of adding fluoride to the drinking water outweigh the financial costs.

6.4. A decision maker must act consistently with a statutory power and the failure to undertake an assessment or to make a decision based on reasonable grounds is an error of law. It appears that the Director-General has followed the outdated and biased government policy rather than fulfilling his duty of fairness and undertaking a proper inquiry and assessing the required factors on reasonable grounds. One example, and there are numerous other examples, of the Director-General not undertaking a proper inquiry is set out below.

6.5. The *Guidelines for the Use of Fluorides* ("the Guidelines") on the MOH's website warn about the amount of topical fluoride to be used and the use of fluoride toothpaste less than 1000 ppm may be considered for children aged under 6 years living in fluoridated areas who are at low risk of dental issues. The Director-General has not considered the warnings concerning the weight or age of the children drinking fluoridated water and in particular bottle feed babies given the 2021 Office of the Prime Minister Report which acknowledged that "recent studies continue to show that at very high levels and with chronic exposure, fluoride could potentially have negative neurodevelopmental and cognitive impacts."

6.6. Fluoride's effects depend on the total daily intake of fluoride many sources, including food, and there is no way to regulate an individual's intake of fluoride. The Australian and New Zealand Government's 2017 Report, Australian and New Zealand Nutrient Reference Values for Fluoride[8], states that:

[8] https://www.eatforhealth.gov.au/sites/default/files/2022-10/Supporting_Document_1_-_Fluoride_Intake_Estimates_0_0.pdf

"The New Zealand Food Composition tables do not report fluoride content. However, fluoride was analysed in foods and reported in the 1987–88 and 1990–91 New Zealand Total Diet Surveys (NZTDS) (IESR & MOH 1994, Hannah et al. 1995)."

6.7. In addition, the Ministry of Agriculture and Forestry's *2009 NEW ZEALAND TOTAL DIET STUDY* Agricultural compound residues, selected contaminant and nutrient elements does not report on fluoride in our food. A nutrition risk assessment report undertaken by Foods Standards Australia New Zealand (FSANZ) dated 11 November 2008[9] observed that the prevalence of very mild and mild fluorosis was 10% to 25% in Australian and New Zealand children. This is associated with exposure from several sources, both individually and collectively, including fluoridated water, toothpaste, other dental products and supplement use. **The prevalence is usually higher in fluoridated than non-fluoridated areas**. The FSANZ report did not identify any evidence of more severe forms of fluorosis.

Proper inquiry / reliance on flawed reports

6.8. When exercising a power of discretion, a decision maker is expected to be adequately informed as to the relevant considerations[10] The information does not need to be conclusive or all-embracing but must be sufficiently comprehensive and reliable to enable a decision to be made on an informed basis[11]. A decision can also be invalidated if officials fail to provide fair, accurate or adequate information[12].

6.9. A decision that is based on inadequate or misleading information is not a reasonable exercise of a discretion. In relation to a statutory threshold, the adequacy of the information may impact on whether the statutory requirements are met.

6.10. The Director-General's decision was made on reliance of outdated and biased government policy and information which included inconsistencies and omission of important information. Examples of the reliance on outdated and biased government policy and information for the directives are set out above in this letter.

Duty of Fairness

6.11. The Director-General has a duty of fairness and to think carefully about the persons being affected by the decision and how they will be affected. The greater the potential impact on a person or group, the greater requirements of fairness especially where there is an adverse

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[9] www.foodstandards.govt.nz/sites/default/files/food-standards-code/applications/Documents/A588%20Fluoride%20-%20Supporting%20Document%202%20-%20Nutrition%20Risk%20Assessment.pdf

[10] *Auckland City Council v Minister of Transport* [1990] 1 NZLR 264 (CA) at 303 where Richardson J notes that a Minister's duty "to exercise [his] discretion on reasonable grounds necessarily requires that the Minster be adequately informed as to the relevant considerations and that he take them into account".

[11] 22 *Northcote Mainstreet Inc v North Shore City Council* [2006] NZRMA 137 (HC) AT [11].

[12] See for example Air Nelson Ltd v Minister of Transport [2008] at [40], [51], [53].

impact. The MOH Appendix[13] to Next Steps Letter states that there were 1,674,201 people in non-fluoridated community supplies servicing populations of 500 or more.

6.12. The principles of natural justice, including the right to be heard and the rule against bias, are part of the duty of fairness. It should be noted that the Act prohibits a local authority from consultation with the community being affected. Parliament is supreme legislative power and it is clear that the former government intended to take away the democratic process of consultation. In such circumstances the duty of fairness and the rule against bias is vital to the Director-General's statutory decision. The rule against bias ensure that all relevant matters are taken into account to discharge the statutory duties under the Act.

Failure to Discharge Duties

6.13. While the Director-General can consult with or receive advice from others the Act set out the statutory process and requires the Director-General to must make the ultimate decision independently from other people.

6.14. It would appear that the Director-General's decision to issue directives to 14 councils in July 2022 under the Act was a `rubber stamp' based on predetermined and flawed and biased reports. There is a strong argument that the Director-Geneal acted under dictation and the decision-making power was not properly exercised.

6.15. On 10 November 2021, prior to the Director-General exercising his statutory power of decision-making under the Act, he stated on One News:

> *"I'm very, very pleased to see this decision around fluoridation," he said on Wednesday.*
>
> *Bloomfield said his team would provide advice to him, "and I sign off on fluoridation for communities across the rohe (regions)".*
>
> *"This will have a major impact, not just on child oral health but on inequities in child oral health[14]."*

6.16. If the Director General had fulfilled his duty of fairness and undertaken a proper inquiry and assessed on reasonable grounds of the scientific evidence that supports adding fluoride to the drinking water for every person in a region, he should have considered the following evidence that existed at the time of the assessment:

[13] https://fyi.org.nz/request/19839-local-goverment-implementation-of-water-fluoridation
[14] https://www.1news.co.nz/2021/11/10/law-change-sees-fluoride-water-decisions-in-bloomfields-hands/

(d) Water fluoridation may reduce cavities in children, while efficacy in adults is less clear[15]. The 2024 Cochrane Collaboration adding fluoride to water supplies "may" lead to slightly less tooth decay in children's baby teeth, the researchers could not be sure whether adding fluoride to water reduced tooth decay in children's permanent teeth.

(e) water fluoridation, particularly in industrialized countries, may be unnecessary because topical fluorides (such as in toothpaste) are widely used, and cavity rates have become low[16]. The 2024 Cochrane Collaboration found that the benefits of fluoride in water supplies may be smaller than they were before the widespread addition of fluoride to toothpaste.

(c) While the World Health Organization states water fluoridation, when feasible and culturally acceptable, has advantages, especially for subgroups at high risk[17], the European Commission found no advantage to water fluoridation compared with topical use[18]. Community water fluoridation is rare in continental Europe with 97–98% choosing not to fluoridate drinking water.

6.17. The above factors are a snapshot of the type of factors that the Director-General should have considered to discharge his duties in making the assessment of whether to issue directives or not. If the Director-General had fulfilled his duty of fairness and undertaken a proper inquiry and assessment on reasonable grounds of whether the benefits of adding fluoride to the drinking water outweighed the financial costs, the Director-General had an obligation to consider the health risks, the impact of water and soil pollution from fluoride discharged to waterways, and the cost vs benefit as at 2021 from up to date and unbiased sources.

7. COUNCILS' OBLIGATIONS

7.1. As noted above, section 23 of the Act states it is the duty of local authorities to improve, promote, and protect public health within their district. Councils around New Zealand are concerned about the safety of fluoride being introduced to the drinking water versus the significant penalties if do not follow the directives.

7.2. The former government included strict liability for not complying with a directive in the amends to the Act. There is a fine of $200,000.00 and $10,000.00 a day for a continuing offence. These fine are in well in excess of the other fines in the Act which range from $50 a day to $10,000.00. Parliament is supreme legislative power. However, the Court have a duty to ensure that the

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[15] https://repository.uel.ac.uk/download/f18682bf27561331a9b3713cda2f22c80095c9c24c87220abde0d63273feb2d4/164374/JPHCCochraneCornerDec2013.pdf
https://ec.europa.eu/health/scientific_committees/opinions_layman/fluoridation/en/l-3/1.htm#0
https://sgp.fas.org/crs/misc/RL33280.pdf

[16] https://link.springer.com/article/10.1007/s00784-007-0111-6

[17] https://www.who.int/oral_health/media/en/orh_cdoe_319to321.pdf

[18] https://ec.europa.eu/health/scientific_committees/opinions_layman/fluoridation/en/l-3/5.htm#0

Director-General discharged the statutory duties when such significant fines are being imposed on Council to fluoridate the drinking water for the whole community against human rights.

7.3. The mayor of Tauranga City Council ("**TCC**") recently gave a radio interview following the Director-General denying the TCC an extension following the Bill of Rights High Court Case which the Government is currently appealing. By way of brief summary, the mayor stated[19] that:

(a) **Legality of Directives**: there were questions around whether the directives were lawful.

(b) **Pause Pending Appeal**: he would rather wait for the outcome of the Bill of Rights appeal to ensure that the directive was valid and not have to "flip flop" in six months.

(c) **Oldef Data**: there are question marks in his mind, and he wants to hear it from the Director-General that fluoride is safe given the recent US court ruling and the Director-General relying on "older reports".

(d) **Threat of Large Fines**: the Council feels under pressure due to the large fines and personal liability under the Act.

(e) **Stop Tax rather than Rates**: In response to interviewing asking if the TCC would allow ratepayers to withhold part of their rates, the mayor said he was sympathetic but what he suggests that if ratepayers have an issue with the introduction of fluoride into the city's drinking water that they should stop paying their taxes as it is a central government decision not a council decision.

7.4. If Council are forced to follow the directives, then they should consider their other duties under the Act. Section 23 states that:

> *"… it shall be the duty of every local authority to* ***improve, promote, and protect public health*** *within its district, and for that purpose every local authority is hereby empowered and directed— if satisfied that* ***any nuisance, or any condition likely to be injurious to health*** *or offensive, exists in the district, to* ***cause all proper steps to be taken to secure the abatement of the nuisance or the removal of the condition****".*

7.5. Section 29 of the Act states that without limiting the meaning of the term nuisance, a nuisance shall the deemed to be created in a number of cases including:

> *"...where any well or other* ***source of water supply****, or any cistern or other receptacle for water which is used or is likely to be* ***used for domestic purposes or in the preparation of food****, is so placed or constructed, or is in such a condition, as to render the water therein* ***offensive, or liable to contamination, or likely to be injurious to health****"*

[19] https://realitycheck.radio/replay/mahe-drysdale-mayor-of-tauranga-the-health-director-generals-refusal-to-extend-the-pause-on-the-citys-water-fluoridation/

7.6. Given the research and information that exists at the date of this letter, the Council should consider whether fluoridated drinking water is likely to be injurious to health.

7.7. Section 30 of the Act states that every person that allows a nuisance arises or continues, whether commits an offence against this Act. Section 32 states that the provision of the Act as to nuisances apply to the Crown.

> *"The provisions of this Act relating to nuisances, including any regulations or bylaws thereunder, shall, unless otherwise specifically provided therein, apply to nuisances created by the Government or by any employee thereof in his capacity as such employee."*

7.8. If the incumbent Director-General and the Government do not take the pragmatic approach and review the current directives, then Councils around New Zealand would be advised to consider whether fluoride is a nuisance that needs to be removed from the drinking water supply, and which is discharged into our waterways.

CONCULSION

7.9. If the incumbent Director-General and the Government do not take the pragmatic approach and review the current directives there is no other option but to force further legal action through the Courts. There is tension between the assessed state of knowledge of dental decay and the supposed benefits of fluoridation when the directives were issued and the latest and most up to date assessment, which shows a substantial risk of neurological harm- our children being the group that are considered to be the most affected by tooth decay.

7.10. The world has grappled with numerous instances where, eventually, scientific proof of public harm has triumphed over the lobbying efforts of industry special interests (government policy). Examples include DDT, asbestos, nuclear testing, leaded petrol and paint, mercury amalgams and the many approved pharmaceuticals subsequently found to cause greater harm than benefit. Chemical fluoridation joined this list in many countries many years ago and New Zealand is an outlier, scientifically and legislatively.

7.11. The change in fluoridation policy in New Zealand over time illustrates how political imperative is often divorced from medical science, and that caution should be taken when introducing policy where there are already serious questions. For example, the Guidelines on the MOH's website states:

> *"Fluoride tablets were widely encouraged from the 1950s onwards. The rationale for the use of fluoride tablets was to replicate the intake of fluoride from 1 litre of water a day in a fluoridated area. Fluoride tablets have been shown to be a risk factor for dental fluorosis when not used appropriately9 and there have been problems with a lack of compliance,*

with those least in need of using them being most likely to do so. There is also a risk of acute toxicity from fluoride tablets if excessive numbers are ingested[20]*."*

7.12. The apparent inability or unwillingness of two successive Directors General of Health to engage with the changed fluoride science landscape will prompt an attempt to judicially compel the Director-General to give fair and reasonable consideration to the available evidence, in the course of protecting and promoting public health, which has to include our brains not just our teeth. It is contended that the benefits of adding fluoride to the water are lacking, and the harms are significant and proven consistently by high level evidence which is increasingly embraced by countries and courts worldwide.

7.13. Due to the Director-General denying Councils and an extension pending the High Court appeal, this matter is now urgent. I request a formal response by Wednesday, 23 October 2024.

Yours sincerely

Kirsten Murfitt

Kirsten Murfitt

[20] https://www.health.govt.nz/system/files/2011-11/guidelines-for-the-use-of-fluoride-nov09.pdf