Neutral Citation Number: [2019] EWCA Civ 1239

Case Nos: C4/2017/0748 & C4/2017/3078

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
MR JUSTICE GREEN
[2017] EWHC 196 (Admin) &
NEIL CAMERON QC (SITTING AS A DEPUTY HIGH COURT JUDGE)
[2017] EWHC 2132 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/07/19

Before :

LORD JUSTICE LONGMORE

LORD JUSTICE HICKINBOTTOM
and
LORD JUSTICE PETER JACKSON

- -

Between :

THE QUEEN on the application of
ASK (by his Litigation Friend the Official Solicitor)

Appellant

- and -

THE SECRETARY OF STATE FOR
THE HOME DEPARTMENT

Respondent

- and -

(1) NHS ENGLAND
(2) THE SECRETARY OF STATE FOR HEALTH
AND SOCIAL CARE
(3) THE SECRETARY OF STATE FOR JUSTICE **Interested Parties**

- and -

THE EQUALITY AND HUMAN RIGHTS COMMISSION

Intervener

And between :

THE QUEEN on the application of
MDA (by his Litigation Friend the Official Solicitor)

Appellant

- and -

THE SECRETARY OF STATE FOR
THE HOME DEPARTMENT

Respondent

- and -

(1) NHS ENGLAND
(2) THE SECRETARY OF STATE FOR HEALTH
AND SOCIAL CARE

Interested Parties

- and -

THE EQUALITY AND HUMAN RIGHTS COMMISSION

Intervener

- -

Stephanie Harrison QC and **Leonie Hirst** (instructed by **Bhatt Murphy**)
for the **Appellant ASK**
Amanda Weston QC and **Leonie Hirst** (instructed by **Deighton Pierce Glynn**)
for the **Appellant MDA**
Sir James Eadie QC and **Julie Anderson** (instructed by **Government Legal Department**)
for the **Respondent**
Patrick Green QC and **Christopher Knight** (instructed by **Browne Jacobson LLP**)
for **NHS England**
Holly Stout (instructed by **Government Legal Department**) for **the Secretary of State for Health and Social Care** (written submissions only)
Julie Anderson (instructed by **Government Legal Department**)
for **the Secretary of State for Justice**
Helen Mountfield QC (instructed by **Keith Ashcroft, Equality and Human Rights Commission**) for the **Intervener** (written submissions only)

Hearing dates: 14-16 May 2019
Further written submissions: 23 May 2019

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Approved Judgment

Lord Justice Hickinbottom:

Introduction

1. These appeals raise important issues concerning the powers of the Respondent Secretary of State to detain those who suffer from mental health conditions pending removal from the United Kingdom.

2. In each case, the Appellant is a foreign national who satisfied the statutory criteria for detention pending removal, but who suffered from mental illness such that it is said that, for at least some of the period he was detained, he was not only unfit to be removed and/or detained in an immigration removal centre ("IRC"), but did not have mental capacity to challenge his detention and/or engage with the procedures to which he was subject as a detainee.

3. As a result, it is submitted that, in detaining each Appellant, the Secretary of State acted unlawfully in one or more of the following ways.

   i) He breached his common law duty to act fairly.

   ii) He breached his common law duties to act consistently with the statutory purpose of the detention and rationally, contrary to the well-known common law principles set out by Woolf J in R v Governor of Durham Prison ex parte Hardial Singh [1984] 1 WLR 704 ("Hardial Singh") and article 5 of the European Convention on Human Rights ("the ECHR").

   iii) He breached his own detention policy, and his duty promptly to transfer to hospital a detainee whose mental illness could not be satisfactorily managed within an IRC.

   iv) He breached article 3 of the ECHR because the treatment suffered by the Appellant was degrading treatment proscribed by article 3; but also because the Secretary of State breached the positive duty inherent in article 3 to have in place effective systems to prevent a breach of that article arising from the detention of individuals with mental illness and/or lacking mental capacity and/or a failure to transfer such individuals to hospital. Alternatively, it is said that that same treatment breached article 8 of the ECHR, because it adversely affected the Appellant's enjoyment of his private life. (All references in this judgment to "article 3" and "article 8" are to those articles in the ECHR.)

   v) He breached his duty under sections 20 and 29 of the Equality Act 2010 ("the EA 2010") to make reasonable adjustments to prevent disadvantage to detainees who are mentally ill; and the public sector equality duty under section 149 of the EA 2010 ("the PSED").

4. In the course of this judgment, it will be necessary to look at the facts of each case in some detail but, briefly, MDA is a Somali national, who is a foreign national criminal and the subject of a deportation order. He was detained pending removal immediately following the expiration of the custodial part of a prison sentence on 4 November 2015 until he was released from immigration detention on 3 February 2017 to be

detained in a secure psychiatric hospital unit under section 2 (and, later, section 3) of the MHA 1983.

5. Following a judgment dated 18 August 2017 ([2017] EWHC 2132 (Admin)), Neil Cameron QC sitting as a Deputy High Court Judge ("the Deputy Judge") granted MDA's claim for judicial review, finding that the whole period of detention was unlawful because the Secretary of State's failure to enquire into MDA's mental capacity was a breach of the common law duty of fairness; and, for essentially the same reason, there was a breach of the PSED .

6. The findings made by the Deputy Judge are not challenged by the Secretary of State. However, before us, on behalf of MDA it is submitted by Amanda Weston QC with Leonie Hirst that the Deputy Judge erred in not determining, in MDA's favour, a number of issues including:

   i) whether there had been a breach of article 3;

   ii) whether there had been a breach of sections 20 and 29 of the EA 2010; and

   iii) whether damages should be substantive or nominal.

   In respect of (i), the Deputy Judge held that there was no breach of article 3. In respect of (ii) and (iii), he remitted the issue to the county court for determination.

7. ASK is a Pakistan national. He was an overstayer who was liable to have removal directions served on him; and who was detained pending removal from 17 January 2013 after he was arrested by the police having refused to leave the Isleworth Mental Health Office, until 23 September 2013 when he was admitted to the Low Secure Psychiatric Unit at St Bernard's Hospital, Southall.

8. The claim that ASK's immigration detention was unlawful was heard by Green J who, in a judgment handed down on 9 February 2017 ([2017] EWHC 196 (Admin)), refused it on all grounds.

9. Before us, for ASK, Stephanie Harrison QC with Ms Hirst submitted that the judge erred in a number of ways, and, had he not done so, he would have found the whole of ASK's detention to be unlawful. Ms Harrison helpfully split the detention up into four periods, as follows (in respect of each date, time running notionally from midday).

   i) Period 1: 17 to 31 January 2013: During this period, the Secretary of State failed even to have regard to his own detention policy insofar as it applies to those with mental health conditions.

   ii) Period 2: 31 January to 13 April 2013: Although the Secretary of State had his own detention policy in mind from 31 January 2013, he failed to construe and apply it properly.

   iii) Period 3: 13 April to 18 July 2013: By 13 April 2013, the Secretary of State knew or ought to have known that it was necessary urgently to transfer ASK from the IRC into hospital; and, in not transferring him, he breached his own

policy, his common law duties under the Hardial Singh principles and article 5 of the ECHR.

iv) Period 4: 18 July to 23 September 2013: By 18 July 2013 the Secretary of State had accepted that ASK should be transferred out of an IRC into a hospital; and therefore, it is submitted, ASK continued to be detained, not pending removal from the UK, but pending transfer to hospital. In not releasing ASK during this period, the Secretary of State was again in breach of not only his own detention policy, but also Hardial Singh and article 5.

10. Ms Harrison also submitted that, throughout the whole period of ASK's detention:

i) the Secretary of State's treatment of ASK breached his rights under article 3 and/or article 8;

ii) the Secretary of State's failure to enquire into MDA's mental capacity was a breach of the common law duty of fairness and, for essentially the same reason, there was a breach of the PSED; and

iii) the Secretary of State's failure to make reasonable adjustments in respect of ASK's mental condition and/or mental incapacity was a breach of sections 20 and 29 of the EA 2010.

11. I have identified the representation for the Appellants. Sir James Eadie QC and Julie Anderson appeared for the Secretary of State; and Patrick Green QC and Christopher Knight for NHS England. In addition, we had the benefit of written submissions on behalf of the Secretary of State for Health and Social Care, the Secretary of State for Justice, and the Equality and Human Rights Commission. At the outset, I thank all of the legal representatives for their contributions.

The Legal Framework

The Immigration Act 1971

12. These appeals involve a number of overlapping statutory schemes; but the starting point is the Immigration Act 1971 ("the IA 1971") which gives the Secretary of State various powers to detain individuals whom he intends to remove from the United Kingdom. MDA was detained under paragraph 2(3) of Schedule 3 which applies to those who have been served with a deportation order. ASK was detained under paragraph 16 of Schedule 2 to that Act which applies to those in respect of whom removal directions may be given. Given that these are powers which interfere with the liberty of the subject, they are to be strictly and restrictively construed (Secretary of State for the Home Department v B (Algeria) [2018] UKSC 5; [2018] AC 418 at [5]); but it is uncontroversial that each Appellant satisfied the particular criteria in the statutory provisions under which he was detained.

13. However, satisfying the statutory criteria is necessary but not sufficient for detention to be lawful: a number of overlapping constraints reflect the state's overarching responsibility to those whom it detains. In particular, it is well recognised that those suffering from mental illness require particular protection when in detention, because of their vulnerability and possible difficulties in communicating complaints or

information about their own condition. Therefore, in addition to complying with those criteria, the Secretary of State must comply with his obligations under (i) the MHA 1983, (ii) the Detention Centre Rules 2001 (SI 2001 SI No 238) ("the Detention Centre Rules"), (iii) the Mental Capacity Act 2005, (iv) his own published detention policy, (v) his duties as a public body to act consistently with the statutory purpose and not to act arbitrarily, i.e. not to act contrary to the relevant common law principles as set out in Hardial Singh and/or article 5 of the ECHR, (vi) his common law duty to act fairly, (vii) articles 3 and 8 of the ECHR and (viii) sections 20 and 29 of the EA 2010 and the PSED. I will deal with these in turn.

The Mental Health Act 1983

14. So far as relevant to this appeal, the MHA 1983 does not impose duties, but rather empowers public authorities (including the Secretary of State) to admit to hospital individuals with mental health conditions to obtain treatment and, in appropriate cases, to be detained for the purposes of obtaining treatment.

15. By section 2, a patient may be admitted to a hospital and detained there for assessment for up to 28 days. By section 2(2), an application for admission for assessment may be made on the grounds that the patient is suffering from mental disorder of a nature and degree which warrants his detention for the purposes of assessment, and that he ought to be so detained in the interests of his own health and safety or for the protection of others.

16. By section 3, a patient may be admitted to a hospital and detained there for treatment. By section 3(2), an application for admission for treatment can be made on the grounds that:

> "(a) he is suffering from mental disorder of a nature or degree which make it appropriate for him to receive treatment in hospital; and
>
> (b) [repealed];
>
> (c) it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and
>
> (d) appropriate medical treatment is available for him."

"Appropriate medical treatment" is defined in section 3(4) as "medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case". That definition expressly applies throughout the Act (see section 145(1AB)).

17. An application under section 2 or section 3 must be made on the written recommendation of two registered medical practitioners who are of the opinion that the relevant conditions are satisfied.

18. Over and above the powers in sections 2 and 3, following conviction for an offence punishable by imprisonment, section 37 gives a criminal court the power to authorise

the convicted person's admission to and detention in a hospital "as may be specified in the order" ("a hospital order"). The court must be satisfied that arrangements have been made with the specific hospital for his admission to that hospital within 28 days (section 37(4)); and, if within 28 days it appears to the Secretary of State that it is impracticable for the patient to be received into the specified hospital, he may give directions for the admission of the patient to such other hospital as appears to be appropriate (section 37(5)). Generally, those who are the subject of a hospital order are treated as if they had been admitted for treatment under section 3, and their discharge is a purely clinical decision. However, for the protection of the public from the risk posed by the offender, the court may add a "restriction order" under section 41, as a result of which the patient can only be discharged by the clinicians with the consent of the Secretary of State.

19. Section 37 is appropriate where a convicted person requires treatment and otherwise satisfies the relevant conditions at the date of his sentence. However, of course, a prisoner's mental state may deteriorate whilst he is in custody. Section 47 concerns "Removal to hospital of persons serving sentences of imprisonment, etc". It provides:

> "(1) If in the case of a person serving a sentence of imprisonment the Secretary of State is satisfied, by reports from at least two registered medical practitioners—
>
> > (a) that the said person is suffering from mental disorder; and
> >
> > (b) that the mental disorder from which that person is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and
> >
> > (c) that appropriate medical treatment is available for him;
>
> the Secretary of State may, if he is of the opinion having regard to the public interest and all the circumstances that it is expedient so to do, by warrant direct that that person be removed to and detained in such hospital as may be specified in the direction; and a direction under this section shall be known as 'a transfer direction'.
>
> (2) A transfer direction shall cease to have effect at the expiration of the period of 14 days beginning with the date on which it is given unless within that period the person with respect to whom it was given has been received into the hospital specified in the direction.
>
> (3) A transfer direction with respect to any person shall have the same effect as a hospital order made in his case."

20. Section 47 only applies to serving prisoners. Section 48 deals with "Removal to hospital of other prisoners", including persons detained under the IA 1971 (section 47(2)(d)). It provides:

> "(1) If in the case of a person to whom this section applies the Secretary of State is satisfied by the same reports as are required for the purposes of section 47 above that
>
> (a) that person is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and
>
> (b) he is in urgent need of such treatment; and
>
> (c) appropriate medical treatment is available for him;
>
> the Secretary of State shall have the same power of giving a transfer direction in respect of him under that section as if he were serving a sentence of imprisonment.
>
> (2) …
>
> (3) Subsections (2) and (3) of section 47 above shall apply for the purposes of this section and of any transfer direction given by virtue of this section as they apply for the purposes of that section and of any transfer direction under that section."

21. For historical reasons (and to avoid the need for the Secretary of State to duplicate arrangements for a relatively small number of transfers of immigration detainees compared with serving prisoners), responsibility for the issue of transfer warrants for all section 48 detainees is undertaken by a specialist team in the Mental Health Casework Section of the Ministry of Justice ("the MHCS").

22. The transfer and remission of adults under sections 47 and 48 is the subject of a Good Practice Procedure Guide published by the Department of Health in April 2011 ("the GPPG"). This emphasises that the Secretary of State has a power, not a duty, to transfer where the statutory criteria (including the relevant medical reports) are met:

> "3.25 The Secretary of State does not have to agree to transfer; the decision is based on whether it is expedient and in the public interest.
>
> 3.26 The Secretary of State takes account of
>
> • any risks associated with the prisoner (escape risk, nature and history of offending, notoriety, victim issues), and the public protection implications
>
> • whether public confidence could be undermined by allowing transfer
>
> • ….

> • whether treatment can be provided in prison
>
> • the length of time the prisoner still has to serve, behaviour and current security category
>
> • medical opinion, past and presenting symptoms and level of clinical risk (e.g. actively suicidal, assaultive)."

23. The GPPG provides a flow chart which, with paragraph 4.5, breaks the process down into three stages, and gives the following suggested time frame:

    i) Stage 1: First required medical report and steps by the Prison Healthcare Team including contact with MHCS, making a referral to the responsible local mental health provider and an appointment for a second medical assessment: within 2 days.

    ii) Stage 2: Second medical assessment completed, and MHCS sent all remain information needed for transfer with confirmation of bed availability in appropriate service: up to 7 days.

    iii) Stage 3: MHCS approves and issues warrant, mental health service provider confirms admission date to prison and prison service arranges escorts and transports prisoner to hospital: up to 5 days.

24. The GPPG also provides:

    i) One of the reporting doctors should represent the service provider that will admit and treat the patient (paragraph 4.17).

    ii) In terms of "Definition of transfer clock start and stop times":

> "3.7 The transfer clock starts when the first doctor's assessment identifies that the criteria for detention under the [MHA 1983] is met. This assessment will provide one of the medical reports required by the Secretary of State and triggers the formal referral to the responsible mental health provider to undertake the second doctor's assessment.
>
> …
>
> 3.8 The transfer clock does not stop during processes to
>
> • resolve differences of clinical opinion
>
> • resolve disputes over commissioning responsibility [see also paragraph 2.6 to the same effect]."

25. There are a number of differences between the criteria for the exercise of the various statutory powers in the MHA 1983, e.g. the requirement in section 48 that the subject is "in urgent need of… treatment" which does not appear in section 37 or section 47.

26. In this context, Ms Harrison submitted that, unlike section 37 (under which, on evidence from the admitting hospital (section 37(4)), the court has to be persuaded that a specific bed in a specific hospital is available) or section 47 (which expressly requires the transfer direction to specify the hospital to which the patient is to be transferred), section 48 does not require the identification of a specific place for the patient's treatment. It only requires that "appropriate treatment is available for him". I did not find Ms Harrison's further submissions on this point entirely consistent. She expressly accepted that the admission of a patient to a particular hospital is a clinical decision; but, as I understood her submissions, she suggested that whether treatment is "available" is dependent simply upon "treatability", and therefore a patient satisfies the section 48 criterion that "appropriate treatment is available to him" if, as a general proposition, his condition is treatable in hospital. That, she submitted, was sufficient to trigger the Secretary of State's obligation to make a transfer direction under section 48.

27. In any event, however they are put, I am unable to accept those submissions,. I consider the relevant statutory provisions clear. As Ms Harrison accepted, both section 37 and section 47 require the identification of a specific place in a specific hospital. Section 37 expressly requires the approval of the transferee service provider. If, following that approval, for some extraordinary reason, the identified hospital is unable to admit the patient within 28 days, then the Secretary of State can redirect the order to another hospital which he considers "appropriate". Ms Harrison did not suggest that another hospital would be "appropriate" if it did not agree to admitting the patient. It would not be. Clearly, section 37 does not allow a court to override clinical judgment, including an assessment of (i) whether a particular patient can and should be treated at a particular hospital and (ii) the prioritisation of beds. Nor, as Ms Harrison accepts, does section 47.

28. Ms Harrison emphasised that section 48 does not have the equivalent of section 37(4). The only relevant requirement of section 48 is that "appropriate medical treatment is available to him". That, she submitted, does not require the identification of a specific place. However:

    i) As Sir James Eadie submitted, there is no obvious reason why, unlike the courts under section 37 or the Secretary of State under section 47, the Secretary of State is able to override clinical judgment as to admission to a particular hospital under section 48. Ms Harrison suggested none.

    ii) The criterion in section 48(1)(c) ("… appropriate medical treatment is available *to him*…") strongly suggests that the Secretary of State has to be satisfied, not simply that treatment for the patient's condition is treatable in the sense of hypothetically available but that it is available in practice, i.e. that a hospital place has in fact been identified.

    iii) In my view, the point of construction is put beyond doubt by section 48(3) (quoted at paragraph 20 above), which imports section 47(2) into section 48. By section 47(2), a transfer order ceases to have effect after 14 days "unless within that period the person with respect to whom it was given has been received *into the hospital specified in the direction*" (emphasis added). Whilst there is no express reference in section 48 to the specification of a hospital in the transfer direction, that provision makes clear that the reference in section

48(1) to the Secretary of State having "the same power of giving a transfer direction in respect of him under [section 47]…", by incorporation from section 47, effectively requires the specification of a particular hospital in a transfer direction.

iv) That seems clear to me as a matter of construction of the statutory provisions. However, it is of some comfort that the construction I favour is in line with the general principle that admission to a hospital is a decision based on clinical judgment alone; and it avoids the impracticability of a patient being foisted upon a clinician who (e.g.) does not consider that in-patient treatment is necessary or clinically appropriate, or does not consider that the patient can or should be treated in that particular facility.

29. Before leaving the MHA 1983, I should refer to one other provision which features in these appeals. In respect of persons who cease being detained under sections 3, 37, 47 or 48, section 117 imposes a duty on relevant local health services and social services to provide for after-care services until they are satisfied that the person concerned is no longer in need of such services. Section 117(6) defines "after-care services" as services which arise from or are related to the person's mental disorder, and which reduce the risk of a deterioration of the person's mental condition.

The Detention Centre Rules 2001

30. Generally, those who are not otherwise lawfully in the UK cannot claim any entitlement to remain here in order to continue to benefit from medical assistance (N v United Kingdom (2008) 47 EHRR 885 at [42], and GS (India) v Secretary of State for the Home Department [2015] EWCA Civ 40; [2015] 1 WLR 3312 at [67]).

31. However, of course, the state owes healthcare obligations to those it detains. Regulation 11 of the National Health Services Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (SI 2012 No 2996) imposes a duty on NHS England ("NHSE") to "arrange, to such extent as it considers necessary to meet all reasonable requirements" for the provision to persons detained in IRCs of healthcare services including community services, secondary care services and other "rare" services specified in Schedule 4 which include adult secure mental health services.

32. As for the standard of treatment, detainees are entitled to "appropriate" treatment, i.e. not at the same level available in the best health facilities outside detention, but nevertheless a standard of health care equivalent to that generally provided to the population as a whole (R (O) v Secretary of State for the Home Department [2016] UKSC 19; [2016] 1 WLR 1717 at [29]; and Rooman v Belgium (European Court of Human Rights ("ECtHR") Application No 18052/11) [2019] ECHR 105).

33. That principle is reflected in the Partnership Agreement between the Secretary of State, NHSE and Public Health England which states (at page 12):

> "• Detainees should receive health care equivalent to that available to the general population in the community with access to services based on clinical need and in line with the Detention Centre Rules; and

> • Health and wellbeing services in IRCs should seek to improve health and wellbeing (including parity of esteem between services which address mental and physical health)...".

34. The Detention Centre Rules, to which reference is there made, set out a detailed framework within which individuals are detained in an IRC.

35. Rules 33-37 deal with "Healthcare". Rule 33 provides that all IRCs shall have a healthcare team including a general practitioner. It does not require all to have in-patient facilities: some IRCs have such facilities, but not all. Rule 34 requires every detained person to be given a physical and mental examination by a medical practitioner within 24 hours of admission, the purpose of which is to ensure not only that the medical needs of the individual are identified promptly and then dealt with appropriately, but also that continued detention is appropriate (R (SW) v Secretary of State for the Home Department [2018] EWHC 2684; [2019] 1 WLR 2193 at [66]). Rule 35 provides (so far as relevant to this appeal):

> "(1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.
>
> ….
>
> (4) The manager shall send a copy of any report under [paragraph] (1)… to the Secretary of State without delay.
>
> (5) The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for his supervision or care."

36. There is a statutory presumption that a person has mental capacity (section 1(2) of the Mental Capacity Act 2005 ("the MCA 2005")). However, although not pressed as a discrete point by Ms Harrison, it seems to me that, on a rule 34 examination or subsequent examination, rule 35(5) requires a medical practitioner to pay special attention to any apparent mental incapacity of a detainee and, if and where it appears necessary, to make arrangements to address any incapacity identified. In any event, similar obligations arise out of the MCA 2005 scheme itself (see paragraphs 39-41 below), and at common law (see paragraphs 63-65 below).

37. Before I leave the Detention Centre Rules, I should refer to rule 40, which also plays a part in these appeals. Under the section heading, "Maintenance of security and safety", rule 40 provides that, where it appears necessary in the interests of security or safety that a detained person should not associate with other detainees, the Secretary of State or manager of a directly-managed IRC may arrange for the detained person's removal from association (i.e. "segregation"). The bases upon which a detainee can be segregated are clear: it is not intended to be, and cannot be used as, a punishment. There is a requirement to give the detainee written reasons for such removal within

two hours of removal (rule 40(6)); and there is a requirement that every removed person is visited at least once every day by an officer of the Secretary of State (or manager of a contracted-out IRC) and a medical practitioner.

38. Finally under rule 41, an IRC officer dealing with a detained person may use force towards the detainee, but only where and to the extent to which it is necessary.

The Mental Capacity Act 2005

39. I have already referred to the presumption of capacity. By section 2(1) of the Act, a person lacks capacity "if at the material time he is unable to make a decision for himself in relation to a matter because of an impairment of, or disturbance in the functions of, the mind or brain". That, and section 3, indicate that capacity is issue specific. Section 2(2) makes clear it may fluctuate over time: "It does not matter whether the impairment or disturbance is permanent or temporary". Lack of capacity must be proved, on the basis of appropriate evidence, on the balance of probabilities (section 2(4)). Where an individual lacks capacity in respect of a particular decision at a particular time, then the person making a decision affecting him must act in his best interests, i.e. engage with him and take steps to ensure he is engaged in accordance with section 3.

40. The Act sets out decision-making criteria and procedures which are designed to be a substitute for the lack of independent capacity of the person to act or take decisions for him or herself; and which, importantly, come into play in circumstances where a person with capacity would take, *or participate in the taking of*, a decision (R (Chatting) v Viridian Housing [2012] EWHC 3595 (Admin) at [100] per Nicholas Paines QC sitting as a Deputy High Court Judge). The Act provides for a range of measures such as the appointment of independent mental capacity advocates ("IMCAs") whose role is to ascertain and represent the views of the incapacitous person to enable decisions to be made in their best interests.

41. That is reflected generally in Chapter 4 of the Mental Capacity Act 2005 Code of Practice, which applies to "anyone who is working with and/or caring for adults who may lack capacity to make particular decisions". Because of the importance of ensuring that decisions are not made by or in respect of an individual without capacity which they do not understand and which may place them at risk, the Code makes clear (at paragraph 4.34) that:

> "[I]t is important to carry out an assessment [of capacity] when a person's capacity is in doubt."

Detention Policy

42. Of the administrative power to detain, Lord Dyson JSC said in R (Lumba) v Secretary of State for the Home Department [2011] UKSC 12; [2012] 1 AC 245 ("Lumba") at [34]:

> "The rule of law calls for a transparent statement by the executive of the circumstances in which the broad statutory criteria will be exercised."

43. The relevant policies were Chapter 55 of the Enforcement Instructions and Guidance (Detention and Temporary Release) ("the EIG") until 12 September 2016, and Adults at Risk in Immigration Detention ("the AAR Policy") thereafter.

44. Paragraph 55.1.3 of the EIG set the scene. It stated as a general proposition:

> "Detention must be used sparingly, and for the shortest period necessary."

45. Paragraph 55.3 dealt with factors influencing a decision to detain. It particularly referred to three, as follows.

i) Imminence of removal, i.e. where travel documents exist, removal directions are set, there are no legal barriers and removal is likely within four weeks. If removal is imminent, then detention or continued detention will usually be appropriate (paragraph 55.2.4).

ii) Risk of absconding: If removal is not imminent, the decision-maker should consider the risk of absconding:

> "The greater the risk of absconding, the more likely it is that detention or continued detention will be appropriate."

This was explained by Lord Thomas of Cwmgiedd CJ in Fardous v Secretary of State for the Home Department [2015] EWCA Civ 931 ("Fardous") at [44]:

> "It is self-evident that the risk of absconding is of critical and paramount importance in the assessment of the lawfulness of the detention. That is because if a person absconds it will defeat the primary purpose for which Parliament conferred the power to detain and for which a detention order was made in the particular case."

iii) Risk of harm to the public.

46. Paragraph 55.10 (usually referred to as "Chapter 55.10") concerned "Persons considered unsuitable for detention". It provided (so far as relevant):

> "Certain persons are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration accommodation or prisons. Others are unsuitable for immigration detention accommodation because their detention requires particular security, care and control.
>
> …
>
> The following are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration detention accommodation or prisons:
>
> …

> • those suffering serious mental illness which cannot be satisfactorily managed within detention…. In exceptional cases it may be necessary for detention at a removal centre or prison to continue while individuals are being or waiting to be assessed, or are awaiting transfer under the [MHA 1983];…"

47. Therefore, the threshold for the applicability of the policy is that the detainee must be suffering from a serious mental illness which cannot be satisfactorily managed within detention (R (Das) v Secretary of State for the Home Department [2014] EWCA Civ 45; [2014] 1 WLR 3538 ("Das") at [67]).

48. Section 59 of the Immigration Act 2016 formally obliged the Secretary of State to issue guidance specifying matters to be taken into account in determining whether a person would be particularly vulnerable to harm if detained, and whether, if a person is identified as being so vulnerable, whether he should be detained.

49. Under that provision, with effect from 12 September 2016, Chapter 55.10 of the EIG was replaced by the AAR Policy which takes a less prescriptive approach. It said, under the heading, "Assessment: General Principles ":

> "The decision making process a decision maker should apply is:
>
> • does the individual have need to be detained in order to effect removal?
>
> • if the answer is no, they should not be detained
>
> • if the answer is yes, how long is the detention likely to last?
>
> • if the individual is identified as an adult at risk, what is the likely risk of harm to them if detained for the period identified as necessary to effect removal given the level of evidence available in support of them being at risk?
>
> If the evidence suggests that the length of detention is likely to have a deleterious effect on the individual, they should not be detained unless there are public interest concerns which outweigh any risk identified. For this purpose, the public interest in the deportation of foreign national offenders ('FNOs') will generally outweigh a risk of harm to the detainee. However what may be a reasonable period for detention will likely be shortened where there is evidence that detention will cause a risk of serious harm. Where the detainee is not an FNO, detention for a period that is likely to cause serious harm will not usually be justified.
>
> An individual will be regarded as being an adult at risk if:

> - …
> - those considering or reviewing detention are aware of medical or other professional evidence which indicates that an individual is suffering from a condition, or has experienced a traumatic event (such as trafficking, torture or sexual violence), that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention – whether or not the individual has highlighted this themselves
> - …
>
> The nature and severity of a condition, as well as the available evidence of a condition or traumatic event, can change over time. Therefore decision makers should use the most up-to-date information each time a decision is made about continuing detention."

50. The AAR Policy assists with the weight of evidence by referring to "Evidence levels", the highest being level 3:

> "Once an individual has been identified as being at risk, by virtue of them exhibiting an indicator of risk, consideration should be given to the level of evidence available in support, and the weight that should be afforded to the evidence, in order to assess the likely risk of harm to the individual if detained for the period identified as necessary to effect their removal:
>
> …
>
> **Level 3**
>
> Professional evidence (for example from a social worker, medical practitioner or NGO) stating that the individual is at risk and that a period of detention would be likely to cause harm – for example, increase the severity of the symptoms or condition that have led to the individual being regarded as an adult at risk, should be afforded significant weight. Such evidence should normally be accepted and any detention justified in light of the accepted evidence. Representations from the individual's legal representative acting on their behalf in their immigration matter would not be regarded as professional evidence in this context."

51. Further guidance is given in relation to this evidence level 3:

> "Where on the basis of professional and / or official documentary evidence, detention is likely to lead to a risk of significant harm to the individual if detained for the period

> identified as necessary to effect removal, they should be considered for detention only if one of the following applies:
>
> - removal has been set for a date in the immediate future, there are no barriers to removal, and escorts and any other appropriate arrangements are (or will be) in place to ensure the safe management of the individual's return and the individual has not complied with voluntary or ensured return
>
> - the individual presents a significant public protection concern, or if they have been subject to a 4 year plus custodial sentence, or there is a serious relevant national security issue or the individual presents a current public protection concern
>
> It is very unlikely that compliance issues, on their own, would warrant detention of individuals falling into this category – though non-compliance should be taken into account if there are also public protection issues or if the individual can be removed quickly."

52. In addition to general guidance on balancing risk to detainees with the public interest in detaining them, under the heading "Mental health conditions", it states (at page 6):

> "Consideration should be given, on the basis of available information, to whether the condition or impairment can be managed within detention through medication or through other interventions. Even if a condition or impairment can be managed in detention, an individual must still be treated as at risk as defined in this policy, and the presumption will be that detention is not appropriate."

53. A second version of the AAR Policy was published in December 2016 but, for the purposes of these appeals, in substantively similar terms.

54. It is well-established that, whilst the true construction of a policy such as the EIG or AAR Policy is a matter for the court, the decision to detain is discretionary. Therefore, subject to the Hardial Singh principles under which it is for the court to consider whether a reasonable time in detention has been or is likely to be exceeded (see paragraphs 55 and following below), the decision by the Secretary of State's to keep an individual in detention is subject to challenge only in accordance with the ordinary principles of public law (including Wednesbury), to determine whether the decision-maker has acted within the limits of the discretionary power conferred on him by the statute (see R (LE (Jamaica) v Secretary of State for the Home Department [2012] EWCA Civ 597 ("LE (Jamaica)") at [29]).

Hardial Singh and Article 5 of the ECHR

55. Where a power is delegated to a public body, there is a presumption that Parliament intended it to be exercised reasonably.

56. Powers of detention are restrictively construed; and, as a general principle, without the clearest words, Parliament is not taken as intending the power to be used to authorise administrative detention for unreasonable periods or in unreasonable circumstances (Tan Te Lam v Tai Chau Detention Centre [1997] AC 97 at page 111D-E per Lord Browne-Wilkinson). The common law gives effect to that restriction through the principles set out by Woolf J in Hardial Singh, which were approved by Tan Te Lam at page 111A-D. They are now well-established.

57. The principles were helpfully summarised by Dyson LJ in R (I) v Secretary of State for the Home Department [2002] EWCA Civ 888; [2003] INLR 196 at [46], as follows:

> "(i) The Secretary of State must intend to deport the person and can only use the power to detain for that purpose.
>
> (ii) The deportee may only be detained for a period that is reasonable in all the circumstances.
>
> (iii) If, before the expiry of the reasonable period, it becomes apparent that the Secretary of State will not be able to effect deportation within that reasonable period, he should not seek to exercise the power of detention.
>
> (iv) The Secretary of State should act with the reasonable diligence and expedition to effect removal."

58. At [48], Dyson LJ added this:

> "It is not possible or desirable to produce an exhaustive list of all the circumstances that are or may be relevant to the question of how long it is reasonable for the Secretary of State to detain a person pending deportation pursuant to paragraph 2(3) of schedule 3 to the [IA 1971]. But in my view they include at least: the length of the period of detention; the nature of the obstacles which stand in the path of the Secretary of State preventing a deportation; the diligence, speed and effectiveness of the steps taken by the Secretary of State to surmount such obstacles; the conditions in which the detained person is being kept; the effect of detention on him and his family; the risk that if he is released from detention he will abscond; and the danger that, if released, he will commit criminal offences."

59. A detainee's psychiatric condition is a further factor to be taken into account in assessing a reasonable period for detention (see R (M) v Secretary of State for the Home Department [2008] EWCA Civ 307 at [39] per Dyson LJ, and Lumba at [218] per Baroness Hale of Richmond JSC). As Dyson LJ put it in M:

> "I accept that, if it is shown that a person's detention has caused or contributed to his suffering mental illness, this is a factor which in principle should be taken into account in assessing the reasonableness of the length of the detention. But

> the critical question in such cases is whether facilities for treating the person whilst in detention are available so as to keep the illness under control and prevent suffering. It is the view of the in-house psychiatrist at Colnbrook Healthcare (under whose care the appellant is while he is in detention) that he does not have a serious condition such as would require his treatment elsewhere. He has not been assessed as unfit to remain in detention, where his condition is being managed."

60. Under principle (iii), mere uncertainty is insufficient: the state is only required to release a detainee when there is no real prospect of removal within a reasonable time (R (Muqtaar) v Secretary of State for the Home Department [2012] EWCA Civ 1270; [2013] 1 WLR 649 ("Muqtaar") at [36]-[38]). In any challenge, it is for the court itself to determine what is a reasonable period for the purposes of principle (i) or (iii), and whether it has been exceeded (R (A) v Secretary of State for the Home Department [2007] EWCA Civ 804 at [71]-[75]; and LE (Jamaica) at [29(ii)]). However, it must do so without recourse to hindsight (Fardous at [42]). There is a considerable area of judgment in relation to what a reasonable period is in all the circumstances, and, on appeal, this court will not interfere unless it is shown that the conclusion of the court below is inconsistent with the facts as found, or based on an error of law, or not sensibly open to the court on the facts as found (Muqtaar at [46]-[48]). It will consequently be rare for this court to interfere on appeal (see MH at [73] per Longmore LJ; and Muqtaar at [46]).

61. Article 5(1) of the ECHR provides, so far as relevant:

> "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> …
>
> (f) the lawful arrest or detention… of a person against whom action is being taken with a view to deportation or extradition."

62. As in I itself (see [8]), although each Appellant relied on article 5 in the alternative to the Hardial Singh principles, it was not suggested that the Strasbourg jurisprudence added anything of substance to the common law. I will consequently focus exclusively on the latter.

The Common Law Duty of Fairness

63. In addition, where a power is delegated to a public body, there is a presumption that Parliament intended it to be exercised fairly. The scope of that duty is context specific. In these appeals, two strands are particularly relevant.

64. First, a public body has a common law duty to take reasonable steps to acquaint itself with material relevant to any decision it makes – and then properly to consider that information, with the other relevant information available to it – to enable it to make a

properly informed decision. The sufficiency of the inquiry is essentially a matter for the decision-maker; but the context may require particular steps to be taken.

65. Second, procedural fairness usually requires that a person adversely affected by a decision by a public body will have an opportunity to make representations on his own behalf either before the decision is taken or, in some circumstances, after it has been taken with a view to producing its withdrawal or modification (R v Secretary of State for the Home Department ex parte Doody [1984] 1 AC 531 at page 560D per Lord Mustill).

Articles 3 and 8 of the ECHR

66. Article 3 of the ECHR provides:

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

67. It is uncontroversial that conditions of detention (including a failure to give a detainee appropriate medical treatment and/or transfer him when in need of hospital treatment) may result in a detainee suffering inhuman or degrading treatment (see, e.g., Keenan v United Kingdom (ECtHR Application No 27229/95) (2001) 33 EHRR 913 ("Keenan") at [110], Pretty v United Kingdom (ECtHR Application No 2346/02) (2002) 35 EHRR 1 ("Pretty") at [50]-[51], R (S) v Secretary of State for the Home Department [2011] EWHC 2120 at [190] and R v Drew [2003] UKHL 25 at [19]).

68. In these appeals, the primary context in which article 3 arises is as a result of a contention, made by both Appellants, that their treatment in IRCs was degrading and therefore amounted to a breach of the article. The relevant principles for the application of article 3 in this context were helpfully extracted from the Strasbourg authorities (notably Kudla v Poland (ECtHR Application No 30210/96 (2002) 35 EHRR 11) by Singh J (as he then was) in R (HA (Nigeria) v Secretary of State for the Home Department [2012] EWHC 979 (Admin) ("HA (Nigeria)") at [174] as follows (cross-references omitted):

> "(1) Article 3 enshrines one of the most fundamental values of democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances and the victim's behaviour.
>
> (2) However, ill-treatment must attain a minimum level of severity if it is to fall within the scope of article 3. The assessment of this minimum is, in the nature of things, relative: it depends on all the circumstances of the case, such as the nature and context of the treatment, the manner and method of its execution, its duration, its physical or mental effects and, in some instances, the sex, age and state of health of the victim.
>
> (3) The Court has considered treatment to be inhuman because, inter alia, it was premeditated, was applied for hours at a stretch, and caused either bodily injury or intense physical or mental suffering.

> (4) It has deemed treatment to be degrading because it was such as to arouse in the victim feelings of fear, anguish and inferiority capable of humiliating and debasing them.
>
> (5) On the other hand, the court has consistently stressed that the suffering and humiliation involved must go beyond that inevitable element connected with a given form of legitimate treatment or punishment. Measures depriving a person of liberty may often involve such an element.
>
> (6) It cannot be said that article 3 lays down a general obligation to release a detainee on health grounds or to place him in a civil hospital to enable him to receive a particular kind of medical treatment. Nevertheless, the state must ensure that a person is detained in conditions which are compatible with his dignity and that the manner and method of execution of measures used do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his health and well-being are adequately secured by, among other things, providing him with the requisite medical assistance."

69. As Singh J suggests, not only must the suffering and humiliation be over and above that inevitable in legitimate detention, a high level of suffering is usually required, variously put in terms of (e.g.) "…intense suffering …" (Iovchev v Bulgaria (2006) (ECtHR Application No 41211/98) [2006] ECHR 97 at [133]); "… serious suffering…" (R (Limbuela) v Secretary of State for the Home Department [2005] UKHL 66 at [8] per Lord Bingham), or "… intense physical or mental suffering" (Pretty at [52]).

70. Paragraph (4) of the extract from Singh J's judgment, deriving originally from Republic of Ireland v United Kingdom (1978) EHRR 25 at [167], focuses on the effects of the treatment on the individual. Indeed, the Strasbourg jurisprudence (exemplified by Bouyid v Belgium (ECtHR Application No 23380/09) (2016) 62 EHRR 32 ("Bouyid") at [87], to which we were referred by Ms Weston) is to the effect that ill-treatment that attains the appropriate minimum level of severity usually involves the relevant individual suffering evidenced actual bodily harm or intense physical or mental suffering.

71. However, in this respect, although subjective suffering will often be crucial evidence, the threshold test is objective, as Keenan illustrates. As the ECtHR said in Bouyid (at [87]), after referring to the usual involvement of some identifiable and evidenced injury of suffering:

> "However, even in the absence of these aspects, where treatment humiliates or debases an individual, showing a lack of respect for or diminishing his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral or physical resistance, it may be characterised by degrading and also fall within the prohibition set forth in article 3. It should also be pointed out that it may

> well suffice that the victim is humiliated in his own eyes, even if not in the eyes of others."

72. Where a person does suffer actual injuries whilst in the detention of the state, that is treated as a violation of article 3 unless the state can provide an adequate explanation for the harm caused. In those circumstances, the burden of proof effectively falls upon the state. Otherwise, generally, for practical purposes, an individual complainant has the burden of showing that he has suffered the ill-treatment he alleges, and that that amounts to a violation of article 3. He must do that by "conclusively establishing" that he has suffered treatment that could be classified as inhuman or degrading including that any harm suffered was sufficiently serious (Aerts v Belgium (1998) (ECtHR Application No 25357/94) [2000] 29 EHRR 50 at [66]). That is sometimes referred to as "beyond reasonable doubt" but, as the Deputy Judge said in his judgment in MDA (at [116]), that phrase has an autonomous meaning as applied by the ECtHR. Those phrases may (but do not necessarily) connote a standard of proof higher than the balance of probabilities. There is no clear guidance in the cases; other than it is a very high hurdle, and one which complainants generally may not find it easy to overcome.

73. Article 3 arises in two other ways in these appeals.

i) As I have already described, article 3 imposes upon the state not only negative obligations to refrain from and avoid individuals being subject to inhuman or degrading treatment, but also positive obligations to take measures designed to ensure that such treatment is not suffered. It is said on behalf of both Appellants that Secretary of State failed to have in place adequate systems to ensure that the Appellants' article 3 and 8 rights were not breached.

ii) It is contended on behalf of MDA that, at all material times, the Secretary of State would have breached article 3 had he deported MDA to Somalia because the treatment of those with mental illness there (notably chaining) would be degrading treatment.

74. Article 8 of the ECHR provides that no public authority will interfere with the right to respect for private and family life except as provided by article 8(2), namely "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 uncontroversial that mental health is a crucial part of an individual's integrity and thus private life. It is equally uncontroversial that the public interest in deporting foreign criminals generally falls within the categories involving the prevention of crime and public safety.

75. However, as I explained in SL (St Lucia) v Secretary of State for the Home Department [2018] EWCA Civ 1894 at [25] (and re-emphasised recently in Secretary of State for the Home Department v PF (Nigeria) [2019] EWCA Civ 1139 at [19]), although they each seek to translate the value of human dignity and freedom (which is the very heart of the ECHR) into specific rights of individuals and the same factual matrix may coincidentally engage both article 3 and article 8, the focus of and relevant criteria for the two provisions are very different. In particular, it is wrong in principle to consider that an article 3 claim can be treated in the alternative as an

article 8 claim with the latter simply having a "lower" threshold. The threshold criteria are essentially different in nature, not (or, at least, not only) degree.

The Equality Act 2010

76. The claims bring into play provisions within the EA 2010 relating to (i) the PSED and (ii) the duties not to discriminate on the basis of, and to make reasonable adjustments for disability as a protected characteristic.

77. The "have due regard" obligations of the PSED arise out of section 149 of the Act, which (so far as relevant to these appeals) provides:

> "(1) A public authority must, in the exercise of its functions, have due regard to the need to—
>
> (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
>
> (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
>
> (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
>
> (2) …
>
> (3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
>
> (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
>
> (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
>
> (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
>
> (4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

> (5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
>
> (a) tackle prejudice, and
>
> (b) promote understanding.
>
> (6) Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.
>
> (7) The relevant protected characteristics are—
>
> …
>
> disability;
>
> …".

78. The substantive obligations relevant to these appeals, i.e. in the claims that the Appellants as detainees suffered from discriminatory treatment, arise from the following provisions of the Act.

i) Section 29(7)(b) provides that "[a] duty to make reasonable adjustments applies to… a person who exercises a public function that is not the provision of a service to the public or a section of the public".

ii) Section 20(3) provides that the duty to make reasonable adjustments includes "a requirement, where a provision, criterion or practice of [the body exercising the public function] puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage".

a) By section 6(1), "a disabled person" includes a person with a "mental impairment" where "the impairment has a substantial and long-term adverse effect on [their] ability to carry out normal day-to-day activities". It is uncontroversial that each of the Appellants falls within this definition.

b) By section 212(1), "substantial" means "more than minor or trivial".

c) By paragraph 2(5) of Schedule 2:

> "Being placed at a substantial disadvantage in relation to the exercise of a function means… if a person is or may be subjected to a detriment in the exercise of the function, suffering an unreasonably adverse experience when being subjected to the detriment". "

iii) Section 21 provides (so far as relevant to these appeals):

> "(1) A failure to comply with [the duty in section 20(3)] is a failure to comply with a duty to make reasonable adjustments.
>
> (2) A discriminates against a disabled person if A fails to comply with that duty in relation to that person".

iv) Section 136(2) and (3) provides for the burden of proof as follows:

> "(2) If there are facts from which the court could decide, in the absence of any other explanation, that a person (A) contravened the provision concerned, the court must hold that the contravention occurred.
>
> (3) But subsection (2) does not apply if A shows that A did not contravene the provision."

79. The EA 2010's Statutory Code of Practice states that the duty is anticipatory and continuous, and only requires the body exercising a public function to take such steps as are reasonable, which will depend on all the circumstances of the case (see paragraphs 7.20-7.21, and 7.24).

MDA: The Facts

80. MDA has a long immigration and medical history, which is comprehensively set out in the Deputy Judge's judgment at [11]-[102], and also in the determination of the First-tier Tribunal (Immigration and Asylum Chamber) (First-tier Tribunal Judge O'Callaghan) promulgated on 8 January 2019 at [16]-[92]. In view of the now relatively limited grounds of appeal, it is unnecessary to set it out here at such length. The material parts of the factual background are as follows.

81. MDA is a national of Somalia, and was born in Mogadishu on 18 April 1994. He arrived in the UK on 15 September 2008 as an apparently unaccompanied and undocumented asylum-seeking child. He said that his family had been killed in the civil war, and he had been recruited by the militia. He had escaped in 2005, and he came to the United Kingdom via Libya and Italy.

82. He claimed asylum. In the screening interview, when asked if he had any medical conditions, he replied:

> "Yes I'm broken. On many occasions I have tried to harm myself, burn myself. This is caused by an invisible person following me".

On 18 March 2011, the Secretary of State refused his application for asylum; but granted him discretionary leave to remain for three years, "because of your medical condition". In the deportation minute dated 17 September 2015, it is recorded:

> "On 18 March 2011 the asylum was refused, and he was granted discretionary leave until 17 March 2014 on the basis of article 3 – medical conditions in Somalia".

83. In respect of the history, two strands dominate the years from MDA's arrival in the United Kingdom to his immigration detention in 2015 of which he complains: MDA's health, and his criminal behaviour.

84. Following a medical assessment in connection with his asylum application, on 31 October 2008, he was admitted to hospital under section 2 of the MHA 1983. He was discharged on 27 November 2008, and placed in residential care as a looked after child, but his behaviour (sometimes described as psychotic) gave frequent cause for concern. In April 2010, he set fire to the children's home in which he was staying, resulting in him being detained under section 3 of the MHA 1983 until June 2013 by when he was 19 years old. He was then discharged; but detained again under section 2 in the following month, having been found naked in the street touching his own private parts. However, he was not detained in hospital further after assessment. In September 2013, he was arrested for carrying a blade and was remanded in custody, where he was noted as acting "bizarrely". He pleaded guilty to the offence, and was sentenced to eight weeks' detention; but a decision was taken not to deport him.

85. However, within two weeks of being released from custody for the blade offence, he was sentenced to four weeks for criminal damage, and returned to a young offenders' institution. While there, he was transferred to a secure unit at the Herschel Prins Centre at Glenfield Hospital under Dr Thomas, under section 48 of the MHA 1983 and later under section 3. He expressed a wish to return to Somalia; but his mental capacity was questioned. He was diagnosed, not with a psychotic disorder, but with "Dissocial Personality Disorder and Mental and Behavioural Disorders due to use of illicit substances".

86. In March 2014, whilst in hospital, MDA made an application for further leave to remain, although also still expressing the wish to return to Somalia where his mother was. That application was withdrawn in March 2015, on the basis that the Secretary of State would arrange his flight from the United Kingdom.

87. In December 2014, he sexually assaulted a member of staff on the psychiatric ward, and was remanded in custody. MDA, now represented by solicitors, again expressed a wish to be returned to Somalia. On 5 January 2015, a consultant psychiatrist (Dr Stocking Korzen) certified his fitness to fly in these terms, that "[MDA] does not suffer from any mental disorder which would jeopardise or impair his ability to travel by any means available and possible which includes by aeroplane"; but his application for voluntary return was rejected because of his impending trial. His behaviour worsened in prison: he was unresponsive, refused to have a shower or change clothes, urinated on the floor and refused food. He suffered hallucinations, and was prescribed olanzapine (an anti-psychotic) which improved his condition. In April 2015, he was sentenced to 18 months for outraging public decency and the sexual assault.

88. That sentence triggered the automatic deportation provisions of section 32 of the UK Borders Act 2007, by which a foreign national who is sentenced to more than 12 months' custody must be deported, subject to the exceptions in section 33 including

that deportation will breach the ECHR. MDA did not respond to the deportation one-stop notice, and indeed still said that he wished to return to Somalia voluntarily.

89. On 4 November 2015, the custodial part of MDA's sentence expired, but he remained in immigration detention pending removal. It is from this date that MDA complains that his detention was unlawful. In the decision to detain, the risk factors were marked as follows: absconding medium, re-offending high and harm medium. That assessment of risk was maintained through various reviews. The first assessment referred to a mental health nurse practitioner's note dated 18 September 2015 confirming that he had mental health problems whilst in prison; but it also referred to Dr Korzen's 5 January 2015 advice that he did not suffer from any mental disorder which jeopardised his fitness to travel, with the implication in the section concerning Chapter 55.10 of the EIG that it was not engaged. It was said that travel documents were expected within 3-6 months. Later reviews took a similar line, effectively relying upon Dr Korzen's advice to the effect that MDA was not suffering from a mental disorder or at least was not suffering from mental disorder which could not be satisfactorily managed in an IRC.

90. In December 2015, Dr Thomas stated that MDA had been discharged from psychiatric care as he had a personality disorder which was not amenable to treatment. MDA was transferred to Morton Hall IRC, where he refused to comply with the induction process or to attend a mental health assessment. It is recorded that he had been off medication for 5-6 weeks. He was observed with a varying and erratic presentation, and a vulnerable adult care plan was opened.

91. In January 2016, the Secretary of State suspended all Somali removals after a request from the Somali Government. On 25 January 2016, the Secretary of State refused various handwritten representations from MDA on the basis that they did not amount to fresh representations; and, although there was reference to "the practice of keeping mentally ill people in chains [being] common in Somalia…", it said that Dr Korzen had confirmed that MDA was not suffering from any mental illness. That decision was not challenged.

92. In March 2016, MDA was transferred to Harmondsworth IRC and was segregated under rule 40 because of his behaviour; and, by 15 March 2016 was noted as being unfit to travel and being managed by health care facilities in the IRC pending assessment for hospital. On 14 April 2016, in the GCID Case Record Sheets, Debbie Eastwood (a healthcare worker at Colnbrook IRC), quoted a report from Dr Guy Hillman (a consultant psychiatrist) referring to MDA's "significant complex medical history", and a concern that he may need a period of stabilisation in hospital of perhaps three months. Dr Hillman concluded:

> "Whilst this presentation persists, on balance in my opinion he's currently unfit to travel, however should he be treated or our understanding of his difficulties change I will update this risk.
>
> He can currently be well-managed by healthcare facilities in the [IRC] pending an assessment for hospital."

93. The 14 April 2016 healthcare and risk assessment refers to a possible psychotic relapse; but, by May 2016, he appeared to be responding to medication. However, throughout 2016, his compliance with medication was variable; as was his presentation.

94. During that year, MDA was segregated under rule 40 a number of times because of his behaviour including, in September 2016, for a period of a month. On at least one occasion (25 September 2016), force or restraint under rule 41 is recorded as being used as a result of a failure to comply with an instruction to move to the secure unit following aggression towards a nurse and staff in the healthcare unit.

95. He was transferred to Brook House IRC on 21 October 2016, and was there assessed by Dr Jose Belda who prescribed olanzapine which (it is recorded) he never in fact took. He refused to engage with Dr Belda, or indeed anyone else. On 17 November 2016, Dr Belda saw him, and he presented as euthymic, without psychotic symptoms. He was not then taking any medication. Dr Belda concluded that, although his diagnosis was not straightforward, MDA was not suitable for detention under the MHA 1983 because he was not exhibiting any psychotic or affective symptoms. He suggested a period of in-patient assessment may be appropriate. On 15 January 2017, an Approved Mental Health Professional (Marina Sowter) expressed the view that MDA lacked mental capacity to understand, weigh up and retain information provided to him regarding his diagnosis and ensuing care needs. Later in January 2017, Dr Syed Ali of the Sussex Partnership NHS Trust prepared an Access/Gate Keeping Assessment, which concluded that (i) MDA did not require urgent transfer to hospital under section 48 of the MHA 1983, but needed a period of detention in hospital for in-patient assessment under section 2, and (ii) MDA lacked mental capacity to make a decision about the proposed treatment. Dr Ali and Dr Belda completed the relevant forms for section 2 detention.

96. In the meantime, in November 2016, solicitors now acting for MDA instructed a consultant psychiatrist, Professor Anthony Stephen Hale, with the express task of giving an opinion on whether MDA had the capacity to instruct them. Despite two attempts, MDA would not see him; but, on 18 November 2016, he was able to certify that MDA lacked capacity for the purposes of instructing solicitors, and the Official Solicitor agreed to act as his litigation friend. On 23 December 2016, Professor Hale prepared a report from the medical records, which concluded that MDA (i) was seriously psychotically unwell, (ii) lacked capacity to consent to or refuse treatment and (iii) required urgent transfer to in-patient care.

97. Relying on the records with which he was provided, Prof Hale prepared a report dated 31 May 2017. He favoured a diagnosis of complex post-traumatic stress disorder ("PTSD") with psychotic features with possible triggers including environmental factors and khat misuse (paragraph 164). In summarising the overall impact of detention on MDA's mental health, he said (at paragraph 184):

> "Detention is likely to have worsened [MDA's] mental health, through retraumatising reminders of childhood and adolescent traumas, by lack of therapeutic environment, inconsistent and poorly planned medical and psychosocial treatment of symptoms of mental illness and a lack of full medical past history considered and a sensitive cultural context. The

> uncertainty over deportation date and progress of appeal processes contributed to low and on occasions labile mood, and a general stressors of detention will have impaired the efficacy of medication and psychosocial treatments attempted. Detention will thus have worsened symptoms of psychosis, depression and suicidality and all symptoms of complex PTSD."

98. As summarised by the Deputy Judge at [184] of his judgment, Professor Hale concluded:

> "(i) The standard of mental healthcare provided to the Claimant during his detention was not adequate for his complex needs.
>
> (ii) Treatment was not offered in a suitable therapeutic environment.
>
> (iii) A person with a psychotic mental health problem who in addition may have a past history of PTSD from events in Somalia should be considered unsuitable for detention which is known to worsen mental health conditions in such patients.
>
> (iv) When transferred from one IRC to another it appears that the new healthcare unit was not provided with adequate information about [MDA's] complex disorder and treatment and care needs.
>
> (v) Various studies indicate that there is a high risk of segregation further exacerbating existing mental health problems."

99. He also found that MDA did not have capacity to instruct solicitors; and it was likely that, from time-to-time, he had lacked capacity to consent to treatment and generally manage his affairs including making decisions on immigration matters (paragraph 185).

MDA: The Proceedings

100. Following pre-action correspondence, solicitors acting for MDA issued judicial review proceedings on 15 December 2016. That day, Jeremy Baker J abridged time for a response, and ordered an early hearing date. By the time of that hearing on 13 January 2017, Dr Belda had confirmed that MDA would be referred that day for urgent admission to a mental health hospital unit; and, at the hearing, Dove J granted permission to proceed and ordered MDA's release "to suitable accommodation" within 21 days. In the event, on the basis of the reports of Dr Belda and Dr Ali to which I have referred, on 3 February 2017 MDA was released from the IRC and detained at the secure Fir Ward of the Chichester Mental Health Centre under section 2 (and then section 3) of the MHA 1983.

101. The substantive judicial review was heard by the Deputy Judge in June 2017, and his judgment was handed down on 18 August 2017. He found that the whole period of detention was unlawful because the Secretary of State's failure to enquire into MDA's mental capacity was a breach of the common law duty of fairness (see [168]); and, for essentially the same reason, there was a breach of the PSED (see [261]). In addition, the Deputy Judge:

    i) found that, in relation to his treatment in detention, there was no breach of article 3 or article 8 (see [170]-[193]);

    ii) refused to determine a claim based on the Hardial Singh principles and the proposition that removal was not going to be possible within a reasonable time (a) from the outset, because of the treatment of mentally ill patients in Somalia notably by chaining them, and (b) from January 2016 when removals to Somalia were suspended, because that claim had never been pleaded; but he indicated that, had he considered it, he would have refused it on the merits;

    iii) refused the claim based on breach of the Secretary of State's own policies (i.e. Chapter 55.10 of the EIG, and the AAR Policy);

    iv) found that the Administrative Court was an inappropriate forum in which to deal with the claim under section 20 and 29 of the EA 2010; and he declined to determine the merits of that claim; and

    v) transferred the issue of quantum (including the sub-issue as to whether damages should be nominal or substantive) to the county court for determination (see [263]-[264]).

102. The findings made by the Deputy Judge are not challenged by the Secretary of State; but Ms Weston submits that he erred in not determining, in MDA's favour, a number of issues. Permission to appeal was granted by this court (Underhill and Hickinbottom LJJ) on 24 July 2018.

103. However, before I deal with the grounds, to complete the chronology, on 18 September 2017 (i.e. a month after the Deputy Judge handed down his judgment), solicitors on behalf of MDA applied to revoke the deportation order made against him on 17 September 2015 on the primary grounds that, if MDA were to be deported to Somalia:

    i) that would breach article 3, because there was a real risk that on return he would be chained as a containment measure and

    ii) in all the circumstances including his mental health issues, that would also be a breach of article 8.

104. On 18 August 2018, the Secretary of State refused that application, but accepted that it met the low hurdle of paragraph 353 of the Immigration Rules in terms of being a "fresh claim" such that MDA had a right of appeal to the First-tier Tribunal (Immigration and Asylum Chamber) against the refusal.

105. MDA exercised that right and, in a determination promulgated on 8 January 2019, First-tier Tribunal Judge O'Callaghan allowed the appeal on both of those grounds.

That decision has not been appealed. MDA is therefore currently enjoying leave to remain on human rights grounds.

106. However, as I understand it, MDA is still being detained in hospital under section 3 of the MHA 1983.

MDA: The Grounds of Appeal

Introduction

107. Before us, Ms Weston submitted that the Deputy Judge erred in not determining, in MDA's favour, the following issues (which I have relabelled for convenience):

i) whether there was any breach of Chapter 55.10 of the EIG and/or the AAR Policy (Ground A);

ii) whether, as a result of his treatment in detention, there had been a breach of article 3 and/or article 8 (Ground B);

iii) whether, as a result of (a) the treatment of mentally ill patients in Somalia and/or (b) the suspension of removals to Somalia, detention was or became unlawful under the Hardial Singh principles because removal was not going to be possible within a reasonable time (Ground C);

iv) whether there had been a breach of sections 20 and 29 of the EA 2010 (Ground D); and

v) whether damages should be substantive or nominal (Ground E).

At the hearing, these were the only matters remaining in issue. I will deal with them in turn.

Ground A: The Secretary of State's Policy

108. In submissions not pressed with any great force orally, Ms Weston submitted that the Secretary of State erred in two respects in relation to the application of his own policy, Chapter 55.10 of the EIG.

i) He took the initial decision to detain – and then decisions to continue to detain – MDA without adequately informing himself of whether and to what extent MDA had a mental illness such as to engage the policy.

ii) He erred in construing "serious mental illness which cannot be satisfactorily managed within detention", by equating the scope of "satisfactory management" of an illness with the absence of a clinical requirement to be hospitalised under section 3 (or equivalent provision) of the MHA 1983, i.e. the error of law made by Sales J (as he then was) in Das.

The submission in (ii) was in essentially the same terms as that made by Ms Harrison in ASK's appeal. Ms Harrison led on the point, and I will deal with the issue when I deal with ASK's grounds of appeal (see paragraphs 217-218 below). For the reasons I give there, I do not find the ground to have been made good.

109. As to (i), the Deputy Judge dealt with that issue at [194]-[212]. He considered some of the most relevant evidence, including (at [205]) Dr Korzen's letter of 5 January 2015, which he (rightly) accepted did not go directly to the question of whether MDA was suffering from a serious mental illness which could not be satisfactorily managed in detention, but rather whether MDA was suffering from a mental disorder which affected his ability to travel. But he (again, in my view, rightly) rejected the contention that the Secretary of State could not take that into account in considering the Chapter 55.10 threshold question. The Deputy Judge also considered as of "particular relevance" (see [211]) the evidence in the GCID Case Record of 14 April 2016 (see paragraph 92 above) that Dr Hillman advised that MDA's illness was then being "well managed" in detention (to which I return below: see paragraph 115).

110. Having reviewed the evidence, the Deputy Judge continued:

> "210. It is clear that the [Secretary of State] took steps to inform herself of the [MDA's] medical condition both when making the decision to detain and during the review process. The form used to minute the detention decision, and to undertake monthly reviews, contains express reference to chapter 55.10 of the EIG. There is no substance in the [MDA's] contention that the [Secretary of State] misunderstood her own policy, or that she misapplied it.
>
> 211. The conclusion reached by the [Secretary of State] that [MDA] was being satisfactorily managed cannot be characterised as being Wednesbury irrational; it was a conclusion that she was entitled to reach on the information before her, in particular the reports of Dr Stocking Korzen, Dr Thomas and the GCID Case Record Sheets relating to communications with the healthcare unit in the immigration removal centre. The GCID Case Record Sheet for 14 April 2016 is of particular relevance as it records that Dr Hillman, a Consultant Forensic Psychiatrist, had advised that the Claimant can currently be well managed."

111. In my judgment, the Deputy Judge was entitled to reach those conclusions on the evidence, both as to the steps which the Secretary of State took to inform himself of MDA's medical condition and as to the Secretary of State's view that his illness was being satisfactorily managed in detention. Both were essentially matters for the Secretary of State to determine, subject to challenge on usual public law grounds. He did not act perversely, or otherwise unlawfully, in relation to his approach to either issue; and the Deputy Judge did not err in drawing the conclusion that he did not.

112. Ms Weston made parallel submissions in relation to the AAR Policy. She rightly did not suggest that, if this ground of appeal failed in respect of Chapter 55.10 of the EIG, it could succeed in relation to the AAR Policy.

113. This ground fails.

Ground B: Article 3

114. Ms Weston submits that the Deputy Judge erred in concluding that, in detaining MDA at all (or, alternatively, for the period that he did), the Secretary of State breached article 3 and/or article 8 because of the conditions in which he was detained, i.e. his treatment regime in detention which exacerbated his mental illness. Her central complaint was that the Deputy Judge erred in concluding that the threshold of severity for article 3 was not met in this case.

115. In dealing with this issue, at [116]-[118] of his judgment, the Deputy Judge referred to the relevant principles as set out by Singh J in HA (Nigeria) (quoted at paragraph 68 above) and Green J in his judgment in ASK (quoted at paragraph 237(i) below), and particularly the relevant "burden of proof". He set out further principles, equally uncontroversial, at [179]-[183]. He then dealt with the ground as put by Ms Weston, as follows:

> "187. It is clear from the records before the court including the Complex Case Review notes, and the Detention Review reports, that [MDA] had access to healthcare when in detention.
>
> 188. It is equally clear from those records that [MDA] was exhibiting what was described as 'inappropriate behaviour'. As an example, the GCID Case Record Sheet for 18 February 2016 records that [he] defecated in his room and later on the landing. The other residents complained about [his] behaviour which they stated had been noisy and disruptive and had lasted for three months. The record states that [he] would press the cell bell, and if a female officer attended in response to his call, he would press the bell all night. The record for 5 March 2016 states that [he] stripped naked even though female staff members were present.
>
> 189. The record for 14 April 2016 states that Dr Hillman a Consultant Forensic Psychiatrist considered [MDA] to be 'currently well managed by healthcare facilities in the Centre pending an assessment for hospital'.
>
> 190. In my judgment, based in particular on Professor Hale's analysis of the medical records and his conclusions, the treatment of [MDA], whether when associating with other detainees or when removed from association did not reach the level of severity to infringe article 3. Professor Hale does not identify such a level of severity. In addition, at the time when transfer to a hospital was contemplated [MDA] was not deprived of treatment only available in hospital and which his mental condition required, indeed the consultant psychiatrist was of the view that his condition was well managed by healthcare facilities in the IRC pending an assessment for hospital.
>
> 191. For those reasons, I find no infringement of article 3."

116. Ms Weston submits that the Deputy Judge's approach, his findings and conclusion that there was no breach of article 3 were unlawful. She particularly relies upon the following.

i) The judge failed to direct himself properly on the effective burden of proof. Given that MDA was in the control of the state and had suffered some form of psychological injury whilst there, that burden was upon the state.

ii) In any event, the judge failed to take into account that, even absent evidence of suffering, article 3 could be breached because of treatment that was degrading in the sense of objectively undignified. In this respect Ms Weston identified some twelve behaviours that she submitted were, singly or in combination, incompatible with MDA's human dignity, e.g. refusing medication, refusing to communicate, being unkempt and defecating himself, being unclean and refusing to clean him room, various bizarre behaviours, being frequently moved from one accommodation to another.

iii) The judge failed to take into account the repeated use of force and prolonged desegregation of MDA.

iv) The judge failed to take into account the expert psychiatric evidence of Professor Hale.

v) Instead of looking at the period of detention as a whole, the judge wrongly relied upon a snapshot of MDA's condition given by Dr Hillman in April 2016 when his illness was regarded as being "well-managed" (see paragraph 92 above).

vi) The judge failed to resolve conflicts in the medical evidence, e.g. between Professor Hale (see paragraphs 97-98 above) and Dr Belda (see paragraph 95 above) on whether MDA's illness was being well-managed in detention.

vii) The judge failed to take into account the fact that MDA, being incapacitous, was not only unable to instruct a lawyer or otherwise challenge or influence decisions made about him, he was unable to communicate his distress, and the impact on him of his deteriorating behaviour, personal hygiene, social isolation and prolonged segregation.

viii) The judge failed to take into account the fact that MDA's detention was not "legitimate": as found by the judge, it was unlawful at all times from November 2015 to February 2017.

ix) The judge failed to take into account the fact that, under article 3, the Secretary of State had a duty to take positive measures to preserve the psychological integrity and well-being of those whom it detains.

117. However, I consider these criticisms of the Deputy Judge are unwarranted: and I am unpersuaded that he erred in making his core conclusion that the treatment of MDA in detention did not breach article 3.

118. In coming to that view, I have particularly taken into account the following.

i) When concerned with conditions of detention, article 3 requires a general view to be taken of all conditions. Ms Weston makes no complaint of the conditions of MDA's detention, except the treatment of his mental illness (including the consequences of that illness, such as segregation).

ii) Article 3 does not generally require the release of a detainee, or his transfer to hospital, on health grounds. The obligation on the state is to ensure that a detainee is detained in conditions which are compatible with his fundamental dignity, including the proper management of any psychiatric condition he may have.

iii) The Deputy Judge correctly directed himself with regard to the applicable principles, which he clearly set out. Ms Weston does not suggest otherwise.

iv) He was clearly entitled to find, as he did, that whilst in detention MDA had appropriate access to primary care at all times and specialist care when required.

v) It is clear that MDA's condition, like so many psychiatric conditions, was variable in presentation. In part (but only in part), the variations in his case were as a result of compliance or non-compliance with his medication. Furthermore, it is equally clear that, leaving variations over time aside, the various clinicians who saw him did not agree about his diagnosis, prognosis or treatment. There is no suggestion from any side that any view of any clinician was not genuine and reasonably held. As Sir James Eadie suggested, it is also relevant that there was a real issue as to diagnosis and whether he was suffering from a treatable psychotic illness or an untreatable personality disorder possibly exacerbated by the use of khat.

vi) The judge referred to the record of Dr Hillman's view as at 14 April 2016 that MDA's illness was being well-managed in the IRC. As I have indicated, Ms Weston did not suggest that that view was not genuinely and reasonably held. In my view, the reference does not suggest that the judge was improperly relying on a snapshot of MDA's condition: he had set out MDA's medical history at great length, and was clearly using Dr Hillman's report to show no more and no less than that, at times during his detention, there was evidence that his condition was being managed well. As Sir James Eadie submitted, the judge was entitled to set that contemporaneous opinion against the *ex post facto* opinion of Prof Hale derived from consideration of the written records alone.

vii) I do not accept that the judge misapplied the burden of proof, insofar as it was relevant. He properly set out the approach in [116] of his judgment; and there is nothing to suggest that he failed properly to apply that which he set out. In this case, he was right to proceed on the basis that the ultimate burden of proving a breach of article 3 fell on MDA; and he had convincingly to demonstrate a breach. Although MDA was in state detention, the state clearly did not deliberately or positively harm him. Indeed, at all times the state was seeking to treat his underlying mental illness, and to alleviate his suffering symptoms from that illness. Although this claim clearly did not turn on the

burden and standard of proof, I do not consider that the judge's approach was wrong.

viii) Although there are circumstances in which article 3 can be shown to be breached without intense suffering, generally such suffering has to be demonstrated by evidence. The judge's focus on evidenced suffering was correct. He relied upon the evidence before him: I do not consider that there is a basis for the contention that MDA, had he been capacitous, would or even may have materially added to that evidence. There is nothing to suggest that MDA did not make his symptoms known to those he saw, including consultant psychiatrists and other healthcare professionals who are trained and experienced in extracting symptoms from those suffering from psychiatric conditions. Indeed, the evidence is that his symptoms, as they were from time-to-time, were clearly identified and recorded.

ix) The evidence of such suffering, outside contemporaneous immigration and medical records and expert evidence, was thin. Contrary to Ms Weston's submission, the judge set out MDA's behaviour upon which she now relies, not only in the chronology, but by way of example in [188] of his judgment in the section in which he dealt with this very issue. The judge found that the Secretary of State was entitled to conclude that MDA's illness was being satisfactorily managed in detention (see [211] of his judgment; and paragraph 110 above). It was not for the judge to make a definitive determination on medical questions upon which the psychiatrists at the time disagreed. He notably looked at the evidence of Professor Hale, which was particularly relied upon by MDA. Although Ms Weston submitted it was explicable because he was not asked to do so, the fact is that Professor Hale did not say that MDA has suffered intensely; and the judge was not wrong to conclude that the findings Professor Hale did make, even taken with the other evidence, did not show suffering at an intensity to reach the article 3 threshold.

x) As did Professor Hale, Ms Weston made some generalisations about the effects of "segregation" on someone with a mental illness and particularly a psychosis. MDA was subject to rule 40 removal from free association on a regular basis. However, in MDA's case, there seems to be no evidence that MDA had any particular relationships with other detainees, or that he suffered during periods of segregation during which generally his behaviour stabilised. On the evidence, the judge was clearly entitled to find – and, in my view, right – to find that the suffering or indignity caused to MDA by segregation was not of the intensity to satisfy the test for breach of article 3. MDA appears to have been the subject of rule 41 force on at least one occasion; but there is no evidence to suggest that he suffered any injuries or psychological harm or distress as a result, and certainly no suffering or indignity, alone or in combination with other such, that would reach the article 3 level.

xi) The judge held that MDA's detention was unlawful, because of a procedural failing. That is not a point of any possible significant weight in considering whether article 3 was breached.

xii) The judge identified that article 3 has not only a negative duty not to take active steps to subject a person to inhuman or degrading treatment, but also a

positive duty to protect the well-being of person detained by the state including by the provision of requisite medical assistance (see, e.g., IM (Nigeria) v Secretary of State for the Home Department [2013] EWCA Civ 1361; [2014] 1 WLR 1870 at [65] per Lloyd Jones LJ (as he then was), and R (VC) v Secretary of State for the Home Department [2018] EWCA Civ 57; [2018] 1 WLR 4781 ("VC") at [114] per Beatson LJ). However, in this case, the Deputy Judge found that medical assistance was available at all relevant times, and that the assistance that was provided satisfactorily managed MDA's illness. On the evidence before him, which he considered with conspicuous care, he was clearly entitled to come to that conclusion; and he equally clearly and properly took this into account in concluding that article 3 had not been breached.

119. For those reasons, I am not persuaded that the Deputy Judge was wrong to conclude that there was no breach of article 3 in this case. Indeed, whilst I appreciate and am sympathetic to the seriousness of MDA's condition and its unpleasant symptoms, in my view this case falls some way short of satisfying the article 3 threshold of seriousness.

120. Nor do I consider the article 8 claim any stronger. Ms Weston did not make any separate submissions on this as a separate head of appeal; but, given the relative nature of article 8 and the importance of not treating article 8 claim as an article 3 claim with simply a lower threshold, I am quite satisfied that the treatment of MDA in detention was not, in all the circumstances, a breach of article 8. His treatment was in all the circumstances justified under article 8(2).

Ground C: Hardial Singh

121. Article 3 played a further part in Ms Weston's grounds of appeal. She submitted that:

i) At no material time could MDA be removed to Somalia because, there, there would be a real risk that, as a mentally ill person, he would suffer degrading treatment in the form of being chained up. To remove him would therefore be a breach of article 3. There was no proper investigation of this risk, because of the lack of procedural safeguard for those in MDA's position; but, in any event, the Secretary of State was aware that returning him would breach article 3 on this basis from 2011 when MDA was given leave to remain on this ground (see paragraph 82 above). From the start of the period detention, the Secretary of State was therefore wrong to conclude that MDA could be removed to Somalia within a reasonable time.

ii) In any event, from January 2016, removals to Somalia were generally suspended. From that date, on this ground too, the Secretary of State was wrong to conclude that MDA could be removed to Somalia within a reasonable time.

122. The Deputy Judge found that this ground had not been pleaded, and it would be unfair to the Secretary of State to determine it. It seems to me that there is force in that, particularly with regard to (i) – but it is unnecessary to determine this ground of appeal on that basis alone.

123. The Deputy Judge in fact dealt with the merits of this ground at [230] and following of his judgment.

124. The Secretary of State had decided on 25 January 2016 that he would not breach article 3 by returning MDA to Somalia on the basis of the treatment of mentally ill patients there, because of Dr Korzen's opinion (see paragraph 91 above). That decision was not challenged. The judge considered that, when considering whether MDA would be removed in a reasonable time, the Secretary of State did not have to anticipate any challenge to that decision.

125. He concluded (at [235]) that:

> "Analysis of the detention review forms from December 2015 to November 2016 shows that [the Secretary of State] was conscientiously reviewing the lawfulness of [MDA's] detention every 28 days or so and applying the correct legal tests."

126. In respect of the suspension of removal to Somalia, he found from the detention review forms that "careful consideration was given to the prospect of removing [MDA] to Somalia" through period of suspension (see [237]). He continued:

> "For example, in May 2016 the authorising officer noted that the only barrier was the resumption of returns to Somalia. A similar entry was made in June 2016. In July 2016 it was noted that the position relating to return to Somalia may soon become more positive. In August 2016 the authorising officer states 'we need to ascertain whether his removal is a likely prospect'. In September 2016 the authorising officer noted 'We have reason to be confident that returns will resume soon'. In October 2016 the authorising officer stated '… I would like us to review where he will sit in our list of priority cases for removal under the MOU'. On 8 November 2016 the authorising officer noted that advice was needed from CST on timescale."

127. He concluded (at [238]):

> "The entries made in the review documents must not be judged with the benefit of hindsight (R (Botan) v Secretary of State for the Home Department [2017] EWHC 550 (Admin) at [96]). Assessing those entries based on the facts known to the [Secretary of State] at the time, it was never apparent that [MDA] could not be removed within a reasonable period."

128. His overall conclusion on Hardial Singh (at [241]) was:

> "… [T]he power to detain was at all times exercised reasonably for the prescribed purpose of facilitating deportation".

129. I cannot conclude that the Deputy Judge, who dealt with this issue with conspicuous care, erred in his approach or his conclusion. He set out the correct approach as a

matter of law – Ms Weston does not suggest otherwise – and he referred to the evidence which he regarded as particularly important, before concluding that, on an objective basis but without the benefit of hindsight, there did not come a time when it was apparent that MDA could not be removed to Somalia within a reasonable time. In my firm view, his assessment is not one with which this court can properly interfere.

Ground D: Section 20 and 29 of the EA 2010

130. In terms of the EA 2010, before the Deputy Judge, it was submitted that, essentially by failing to enquire into MDA's mental capacity, the Secretary of State had breached the PSED; and he had breached section 20 and 29 of the EA 2010 by failing to make anticipatory adjustments to ensure that safeguards were in place that would avoid the disadvantages faced by MDA as a detainee with a disability. The Deputy Judge concluded that there had been a breach of the PSED – but was persuaded that the issue as to whether there had been a breach of the substantive obligation in section 20 and 29 of the EA 2010 should not be determined in the claim before him, but rather in separate proceedings in the county court (see [251] of his judgment). The reason he took that course was that he considered there were material issues as to the nature of MDA's condition arising out of (e.g.) the fact that Professor Hale considered MDA suffers from complex PTSD which has resulted in a lack of capacity, whilst Dr Thomas considered he suffers from a personality disorder. In the Deputy Judge's view, those issues would require consideration of evidence, including an assessment of medical and social work records. They would require findings relating to, not only diagnosis, but also (e.g.) MDA's functionality as a result of the unlawfulness found.

131. Ms Weston submits that the Deputy Judge ought to have dealt with at least liability, if not damages, under those provisions. She relies on the judgment of this court in VC, handed down after the Deputy Judge's judgment, in which this very issue arose in similar circumstances to MDA's case. For the purposes of this ground of appeal, the Weekly Law Report headnote accurately and adequately summarises the analysis of Beatson LJ (with whom Arden and Lewison LJJ agreed), as follows:

> "… [T]he fact that mentally ill detainees were given no assistance in understanding the reasons for, or making representations in respect of, decisions to detain them or segregate them was a 'provision, criterion or practice' which put such persons at a substantial disadvantage compared to detainees who were not mentally ill, for the purposes of section 20(3) of the [EA 2010], with the consequence that the Secretary of State was under a duty to make reasonable adjustments to avoid that disadvantage; that it would have been reasonable for the Secretary of State to have appointed mental health advocates or to provide automatic independent reviews of detention for mentally ill detainees, but this had not been done; and that, accordingly, the Secretary of State had discriminated against the claimant by failing to make reasonable adjustments to the decision-making processes, in breach of her duty under sections 20 and 29(7) of the [EA] 2010…".

132. These findings generally reflected concerns which had been expressed about the application of Chapter 55.10 of the EIG and the lack of adjustments for mentally ill detainees in (e.g.) the Review of the Welfare of Vulnerable Persons (January 2016) commissioned by the Home Office and prepared by Stephen Shaw, which suggested that the application of the policy had resulted in a "wait and see approach" (paragraph 4.35); and a report commissioned by the Royal College of Psychiatrists, Decision-making capacity of detainees in IRCs (October 2017).

133. In VC, this court consequently granted a declaration that the Secretary of State had discriminated against the claimant by failing to make reasonable adjustments to the decision-making processes in breach of section 20 and 29 of the EA 2010 (see [193]).

134. Before us, Sir James Eadie conceded that, in the light of VC, he could not resist the appeal on this ground, nor a declaration in similar terms to that granted in VC. However, he sought a direction that any damages claim should be remitted to the county court.

135. I agree. Whilst I consider Sir James' concession as to the result of the appeal and the declaratory relief was rightly made, in my view the issue of damages is likely to require consideration of evidence, including possibly oral evidence, with which the county court is better equipped to deal that the Administrative Court (or, of course, this court). In respect of the argument that MDA is entitled to the benefit of adverse inferences as a result of the Secretary of State not submitting any evidence in relation to his decision-making process, that arose primarily in the context of the issues as to the nature of the damages to which MDA may be entitled, with which I deal below (see paragraphs 140 and 144).

136. In my view, the damages claim was rightly – and, certainly, not wrongly – remitted to the county court.

Ground E: Substantive or Nominal Damages

137. Having found MDA's detention from November 2015 to February 2017 unlawful, the Deputy Judge asked for further submissions as to quantum (see [263]-[264] of his judgment). Having then considered the written submissions of the parties, by an Order dated 23 October 2017, he simply transferred to the county court all issues relating to damages, including the issue as to whether damages should be nominal or substantive. As I understand it, that claim is currently stayed pending the outcome of this appeal.

138. Ms Weston contends that the Deputy Judge erred in transferring the issue of whether damages should be nominal or compensatory, because, either as a matter of law or because on the facts the issue bears only one response, the damages in this case must be substantial.

139. As her initial submission, as I understood it, Ms Weston submitted that causation was irrelevant to the question of damages as a matter of law. She referred to the judgment of Lord Dyson JSC in Lumba at [65] where he said, succinctly:

> "… [T]here is no place for causation here".

Ms Weston also referred us to the judgments of Lord Walker of Gestingthorpe at [188], and Baroness Hale of Richmond JSC at [201]. She submitted that, properly interpreted, Lumba was authority for the proposition that, whenever the state has no power to detain (as opposed to having power which it exercises wrongly), compensatory damages should flow. In this case, as the Deputy Judge found, because of the Secretary of State's procedural failings, he never had power to detain MDA. Therefore, as a matter of law, MDA is entitled to compensatory damages.

140. In the alternative, Ms Weston submitted that even if MDA was not entitled to compensatory damages as a matter of law, he was on the evidence in this case; because, as in Das and VC (see [68]), the Secretary of State chose to submit no evidence to explain his decision-making in respect of the decisions to detain, and therefore cannot sensibly oppose the adverse inference of fact that, but for the unlawfulness (i.e. even if he could have detained MDA), he would not in fact have detained him.

141. As to the primary submission, in my view this is based on a misunderstanding of the jurisprudence starting with Lumba and reinforced by other cases to which we were referred such as R (OM) Nigeria) v Secretary of State for the Home Department [2011] EWCA Civ 909 and VC. The principles to be derived from these cases are clear.

i) Causation is irrelevant to the question of whether an act of a public body is unlawful (see Lumba at [65]).

ii) Contrary to Ms Weston's submission, whether the public body acted in excess of jurisdiction in the narrow sense or because such jurisdiction has been wrongly exercised has been irrelevant to the issue of lawfulness since Anisminic Limited v Foreign Compensation Commission [1969] 2 AC 147 established that both species of error render an executive act unlawful and a nullity (see Lumba at [66]). The nature of the unlawfulness does not matter, so long as the breach "bears on and is relevant to the decision to detain" (Lumba at [67]). What that phrase may precisely mean is not relevant to this appeal, because the Deputy Judge found the relevant decisions to be unlawful and there is no challenge to those findings – and the unlawfulness did clearly bear upon and was relevant to the decision to detain.

iii) The question of lawfulness (and therefore, in a damages claim, liability) therefore depends on the question "could" the public body have lawfully detained the relevant individual? The Secretary of State could not lawfully detain a person if (e.g.) he could not reasonably do so in the light of his own policy; or could not continue to do so in the light of the Hardial Singh principles (OM at [24], cited and approved in VC at [59]). If he could not detain the individual, then the detention is unlawful.

iv) However, where unlawfulness has been proved, causation is relevant on the question of damages, because generally damages are dependent upon proof of loss. As Baroness Hale said in Lumba (at [212]), damages for unlawful detention are meant to compensate the relevant individual for the loss of his liberty, and he cannot be compensated for the loss of something which he never would have enjoyed.

v) Unlawfulness (i.e. liability) having been proved, compensatory damages therefore turn on the question of whether, being able to do so, the public body "would" have detained the individual.

142. The references in Lumba to which Ms Weston made were to the issue of lawfulness and thus liability, not to damages. Although there were differing views as to "vindicatory damages" – the minority considering they were due in that case – there was unanimity that compensatory damages were reliant on proof of causation.

143. Therefore, I do not find Ms Weston's primary submission made good. Whether (and, if so, the extent to which) causation has been proved is essentially a factual issue which, as a matter of case management, the Deputy Judge was certainly entitled to remit to the county court. Such issues, which require the determination of facts following consideration of (usually oral) evidence, are usually remitted to the General List of the High Court or county court as appropriate. In this case, I am entirely unpersuaded that there were no such issues, such that MDA is in any event entitled to full compensatory damages for the entire period, particularly given the dispute as to his condition and to the consequences of it – including if and when he was incapacitous.

144. Ms Weston relied on this court's approach in VC at [68], where adverse inferences were drawn from the fact that the Secretary of State had not submitted any evidence to explain his decision-making process. She submitted that, in the absence of evidence from the Secretary of State in relation to his decision-making process in this case, this court should draw adverse inferences, notably that the Secretary of State would not have detained MDA had he acted lawfully. However, VC did not lay down as a proposition of law that, without evidence in the forms of statements, such an adverse inference should be made. Indeed, *ex post facto* explanations and assertions as to what would have happened in hypothetical circumstances are always open to the suggestion that they are self-serving. Each case will depend on its own facts: and, as Ms Weston herself conceded, consideration of whether the Secretary of State would have detained MDA in any event "can only be done by reference to the contemporaneous documents" (Supplementary Skeleton Argument, paragraph 33). Sir James Eadie said the Secretary of State did rely on those documents, which (e.g.) disclose the risk factors that the officers took into account when deciding to detain and continue the detention of MDA. Although of course I express no concluded view – which will be for the county court – I cannot say that the evidence now before the court will not be sufficient to show that MDA would have been detained even if the Secretary of State had acted lawfully. Whether the county court allows the parties to adduce further evidence – which they may now wish to do – is of course a matter for that court.

145. I would dismiss this ground of appeal.

MDA: Conclusion and Disposal

146. Therefore, subject to my Lords, I would allow MDA's appeal on what I have called Ground D, and, subject to submissions on its precise form, make the declaration to which I have referred in paragraph 133 above. In relation to any claim for damages in relation to the breach of sections 20 and 29 of the EA 2010, I would remit that to the

county court, to be dealt with and heard with the damages claim already there. Otherwise, I would dismiss his grounds of appeal.

ASK: The Facts and the Proceedings

Introduction

147. ASK is a national of Pakistan. Aged 22 years old, he came to the UK on a student visa valid from 4 February 2010 until 31 March 2011, which was extended until 30 October 2012. His brother was also lawfully here, working; and he helped ASK financially.

148. During 2012, ASK began to exhibit signs of aggression and began drinking heavily. His brother sought medical help for him. On 12 October 2012, he was seen by Dr Morrison, a consultant psychiatrist at the Lakeside Mental Health Unit at West Middlesex University Hospital ("the Lakeside Unit"), and medical reports were also obtained from Dr Chatterjee and Dr Jelley for the purposes of sections 2 and 3 of the MHA 1983. ASK was detained under those provisions at the Lakeside Unit, under the care of Dr Morrison who was his responsible clinician. ASK was treated with olanzapine and Depakote (i.e. sodium valproate, a mood stabiliser), to which he responded well. His condition stabilised and improved, and the drug doses reduced. He was assessed as being low risk.

149. On 31 October 2012, whilst he was at the Lakeside Unit, ASK's leave to remain expired. On 26 November 2012, it is recorded that that he wished to go to Croydon to apply for asylum, and that he hoped to obtain his own accommodation when discharged from hospital. He told a student nurse that he did not have anywhere to go as his brother had been telling his friends that he had a mental problem and they were now reluctant to assist him.

150. ASK was discharged from the unit into the community on 11 December 2012, leaving the premises on 13 December 2012. It seems from later records of conversations between Dr Morrison and another psychiatrist (Dr John Dent) recorded at [155] of the judgment below that Dr Morrison was of the opinion that ASK's condition was not a psychotic condition but rather a personality disorder exacerbated by cannabis and drug use.

151. A West London Mental Health NHS Trust ("WLMH NHST") team risk overview dated 10 December 2012 recorded that his mood and mental state had greatly improved, and he was now calm and appropriate in behaviour interacting well with staff and patients. He had the benefit of section 117 support; and a hotel was arranged for him.

152. However, shortly after discharge, he began drinking alcohol and smoking cannabis heavily. Due to his disruptive behaviour, on 18 December 2012, he was required to move accommodation; and, on 15 January 2013, that second hotel cancelled his room as a result of inappropriate behaviour.

153. That same day (15 January 2013), ASK was assessed by the Community Mental Health Team ("the CMHT"). He admitted to cannabis and alcohol consumption; but was suffering from no psychotic symptoms. During the assessment, he is recorded as

maintaining good eye contact and appearing relaxed. His speech was spontaneous and normal in form and content. His mood appeared objectively euthymic, smiling at times. He was still on medication, which he had with him. He was advised to see his GP for further prescriptions. He was provided with accommodation for the night, and advised that he needed to approach the National Asylum Support Service ("NASS") for his visa application, and support for accommodation and sustenance. He was told to come back to the CMHT base the following day, and they would assist him to access these services.

154. He did return the following day (16 January 2013), the CMHT described him as well-groomed and with a change of clothes; but he was argumentative, making demands for money and provision of "relaxation". He refused to accept the advice given to him that he should contact NASS for support.

Period 1: 17 to 31 January 2013

155. The following day (17 January 2013), ASK once again visited the CMHT base, where he was again given advice and support on his immigration status and welfare. He was seen by a doctor and a social worker, who clearly considered him not to be psychotic; and was discharged under section 117. As I have described (see paragraph 29(ii) above), a patient is only discharged under section 117 when doctors and social services consider he no longer requires support to reduce the risk of a deterioration of the person's mental condition

156. ASK was unhappy about this turn of events: he kept going into the reception area at the base saying that he would not leave the building until his demands were met. The police were called, and attended with an immigration officer. ASK left with the police, and was detained by them.

157. As he was an unlawful overstayer, the following day (18 January 2013), the Secretary of State (Home Office Immigration Enforcement) took over his detention and ASK was moved to Colnbrook IRC where there were in-patient facilities and psychiatric services including access to a consultant psychiatrist. A 24 hour review was scheduled. Documentary records from this period indicate that the Home Office was aware that ASK had, hitherto, been an in-patient at the Lakeside Unit. The documents recorded that he was presently under the supervision of his GP and that he may also have alcohol problems. They also recorded the medication administered to him at the police station. It seems that ASK's previous medical records were obtained reasonably swiftly.

158. On 19 January 2013, Dr Javaid Sultan (a consultant psychiatrist at Colnbrook) saw ASK. He made a diagnosis of possible schizoaffective disorder. However, he noted that ASK was casually dressed, cooperative and denied any suicidal ideation. There was no evidence of florid psychosis. Dr Sultan was of the view that even if ASK was schizoaffective, he was in remission. He considered ASK was both fit for detention and fit to fly.

159. On 20 January 2013, the Appellant was transferred to Morton Hall, an IRC without a psychiatric medical facility. However, within 24 hours, his behaviour there soon gave rise to concern, and a return to Colnbrook was recommended on 21 January. That day, a detention review was conducted, and the recent history of his mental condition

was recorded. In the meantime, steps were in train to effect ASK's removal. Documentation had been submitted to the Pakistani High Commission to obtain an Emergency Travel Document ("ETD"). It was, however, recorded in the review record that there was a need to consult healthcare about removal. On 25 January, removal directions were set for 12 February 2013.

160. ASK returned to Colnbrook IRC on 26 January 2013. He was disruptive, and he was transferred to the medical health unit within the IRC to be better assessed and treated.

161. There is a handwritten note by one of the case workers at the IRC dated 31 January 2013, expressing concern that there was no up-to-date fitness for detention or fitness to fly report, the most recent being that of Dr Sultan on 19 January; although the note also records that the CID notes on 27 January did not indicate that ASK was unfit to be detained or to fly. A request for a further assessment was made, and it was said that, if he was not fit to fly, then the matter should be referred to the UK Border Agency Operational Support and Certification Unit for review. The note also says:

> "If subject suffering from mental health issues he needs to be released to care of independent responsible adult".

162. A formal detention review case worker record dated 31 January 2013 recorded the following:

> "[ASK's] treatment for schizophrenia is ongoing. His health was reviewed on 27/01/[13], by a doctor who stated that his mental illness had stabilised. However when he was transferred back to the detained population, his mental illness began to deteriorate again and he was subsequently transferred back to healthcare medical hold. Bearing in mind, [ASK's] severe mental illness and the likelihood he may not be well enough to attend his [face-to-face] interview on 06/02/[13]). I recommend release to afford him the opportunity to get the vital treatment and family support he requires. We will be able to remove [ASK] on a further date. Next charter is on 15/02/13."

Period 2: 31 January to 13 April 2013

163. By the 19-day review on 5 February 2013, a change for the better in ASK's condition is reported. It is recorded that ASK was fit to be detained and that a fit to fly request had been sent to Colnbrook IRC for their urgent attention. On 7 February 2013, a detention review report recorded that ASK's condition had been managed in detention and that "there is no reason to believe than it cannot be". That day, ASK was interviewed by the Pakistani High Commission, and the contemporaneous notes recorded that a decision confirming nationality was expected imminently. An ETD for ASK was in fact issued by the High Commission on 25 February 2013.

164. Dr Sultan reviewed the case on 9 February 2013. He recorded a diagnosis of schizophrenia; and the fact that ASK was presenting with an agitated mood and expansive/grandiose ideation and some suspiciousness and paranoia. However, he was compliant with his medication, and in Dr Sultan's opinion he remained fit for

detention as he was accepting his medication – although not fit to fly "as further progress needs to be monitored by regular in-put by healthcare team". He said he would review him again in two weeks. As a result of this review, the removal directions set for 12 February 2013 were cancelled.

165. On 20 February 2013, ASK was transferred to the healthcare in-patient unit at Colnbrook. Dr Sultan reviewed ASK on 23 February 2013, when he continued to exhibit signs of schizoaffective disorder, but that he was gradually improving. He remained fit for detention, but he was still unfit to fly.

166. It is clear from the record of the 49-day review on 7 March 2013 that the case worker considered further detention in line with Chapter 55 of the EIG, to which express reference is made. Detention was maintained pending a further report from Dr Sultan. It seems also to have generated a number of questions for Dr Sultan, as to how long ASK had stopped his medication, whether he would be fit to fly with escorts on the next flight on 26 March 2013, whether he was fit for continued detention and, if not, when he would be fit to fly. Removal directions were said to be "very" imminent.

167. Dr Sultan responded to the queries on 9 March 2013. He said that ASK was "partially compliant" with his medication: he was refusing to take olanzapine, but was taking (and had agreed to take higher doses of) Depakote. He remained thought-disordered with flight of ideas, but there had been a "very gradual improvement of his symptoms". Dr Sultan said that ASK was fit for detention but "not fit to fly at present". He said he would review him again in two weeks.

168. The 56-day review on 14 March 2013 maintained ASK's detention. The 70-day review on 28 March 2013 resulted in a lengthy (four-page) minute. At paragraph 4, it said that ASK's health appeared to have deteriorated in detention because he was refusing to take his medication. The history of the "partial compliance" with regard to taking medication is recorded in line with Dr Sultan's notes. It is also recorded that ASK on occasion had refused fluid or foods; but that was not, at that stage, considered to be a material problem. The caseworker assessed ASK expressly against the criteria for the application of Chapter 55.10 of the EIG, as follows:

> "11. It would appear that the subject's constellation of symptoms is attributable to his failure to adhere to his medication regimen. There is no suggestion that this is being caused primarily by his detention (i.e. that the very fact of detention is influencing his failure to comply).
>
> 12. It is debatable whether the subject's symptoms as detailed in Dr Sultan's report on 9 March 2013 engaged the policy but even assuming that it does it is clear that the steps which have been taken by healthcare (close monitoring, varying medication and access to a psychiatrist) and the consequence, albeit gradual, improvement clearly demonstrate that the subject's illness is being satisfactorily managed in detention. The healthcare team still believe that he is fit to be detained.
>
> 13…

> 14. I accept that there is a presumption in favour of release but I do not see anything in the evidence before me which suggests that [ASK] would comply with any conditions attached to temporary admission or bail. His medical history clearly gives rise to a very strong suspicion that he would not be able to comply."

169. Subject to a declaration of fitness to fly, there were no barriers to removal. The caseworker recommended consideration of removal on the next charter flight or on a scheduled flight with medical escorts; with continued liaison with the healthcare team in the meantime with a request for a further report from Dr Sultan.

170. Dr Sultan reviewed ASK again on 13 April 2013. ASK had declined. After referring to the established diagnosis of schizoaffective disorder, Dr Sultan said:

> "He recovered gradually from his psychotic symptoms for a short while but on seeing him today, he is exhibiting relapse of psychotic illness, e.g. paranoia, formal thought-disorder and flight of ideas, pressure of speech and grandiosity.
>
> In my opinion after seeing him today he is not fit for detention and should be admitted in a Psychiatric Hospital for further assessment and treatment. He is non-compliant with oral medication and would benefit from Depot Injection – Not fit to fly."

Period 3: 13 April to 18 July 2013

171. On 17 April 2013, ASK sent a written request for information to the Immigration Office at the IRC:

> "I would like to meet Immigration to discuss the current situation of my case. I would like to know why I have been detained, so that I can forward my case to my solicitor. I would be grateful if you could book an appointment ASAP. Many thanks. "

172. A written response was sent on 19 April 2013, to the effect that ASK had been detained because he was an overstayer:

> "However, due to your medical issues, detention is to be maintained for the interim period. Once you have been treated, you will be removed from the United Kingdom."

173. A referral was made on 24 April 2013 by Dr Sultan to the Colne Ward of the Riverside Centre for Mental Health, which is part of Hillingdon Hospital ("the Colne Ward"). The Colne Ward was the psychiatric intensive care unit to which section 48 transfers were usually made from Colnbrook IRC. In the Psychiatric Intensive Care Unit ("PICU") Referral Form, he made it clear that the referral was under section 48 of the MHA 1983, and indicated that release into the community was in practice not an option given (i) that the behavioural difficulties which accompanied his condition

would put ASK and/or others at risk and which could not be assessed or safely treated in an open acute ward and a significant risk of aggression due to serious mental disorder, and (ii) the risk of "absconding with associated serious risk of suicide, homicide or vulnerable (e.g. due to sexual dis-inhibition or over-activity) in the context of a serious mental disorder". He emphasised the importance of admitting ASK "within the next 24-48 hrs". As Green J observed (in [114] of his judgment), it is clear that Dr Sultan, at least, was of the view that there was no realistic prospect of release into the community; but that he ought to be transferred promptly to hospital.

174. A UKBA Minute Sheet dated 25 April 2013 records that a caseworker had made enquiries as to the likely timescale for transfer to hospital under the MHA 1983; and as to whether his symptoms could be managed in the interim in the IRC. He addressed Chapter 55.10 of the EIG, and noted that in cases such as this detention could only be maintained in "very exceptional circumstances" (thus implicitly accepting that the applicability criteria for that policy were met, i.e. ASK was suffering from a serious mental illness which could not be satisfactorily managed within detention: see paragraph 46 above); but that the guidance recognised that in exceptional circumstances it could be necessary for detention at a removal centre or prison to continue while individuals were waiting to be assessed or were awaiting transfer under the MHA 1983. The caseworker considered that the present case was an exceptional case falling within the scope of Chapter 55.10.

175. On 8 May 2013, ASK was seen by Dr Musah of the Colne Ward. Dr Musah was also of the opinion that ASK needed an urgent medical bed; but the Colne Ward had no beds immediately available. Arrangements were therefore made for the currently responsible clinicians to contact the WLMH NHST who were responsible for arranging admission to hospital under section 48. They indicated that they would immediately pursue this with the Lakeside Unit.

176. On 11 May 2013, Dr Sultan completed the formal medical report for section 48. In it he recorded that ASK's symptoms were fluctuating and he had had a relapse of symptoms due to poor compliance and limitations on offering psychological interventions in detention. He said that there had been "very poor response to treatment plan at IRC", and the need for monitoring and assessment in a psychiatric ward although admission to a high level secure hospital was not required. He said: "Patient lacks capacity and has very limited insight". On 12 May 2013, a second report was completed by a Dr Abu-Sufian Jabbar, who I understand to be another psychiatrist associated with Colnbrook IRC. He confirmed the general state of ASK, and he too considered he lacked capacity and insight.

177. On 15 May 2013, however, during lengthy discussion between the clinicians at the IRC and Dr Morrison, as consultant psychiatrist at the Lakeside Unit, Dr Morrison declined to accept ASK as a patient. It is recorded that this was because ASK had been a patient and had been discharged in January 2013: but perhaps the more potent reason is given in a case note by Dr Morrison on 29 May 2013 after a review. He recorded that ASK was displaying no signs of psychosis or any other serious mental disorder, and he did not believe he required transfer to an acute psychiatric ward such as the Lakeside Unit provided. There therefore emerged a strong clinical disagreement between the clinicians at the IRC and those at the Lakeside Unit (where the WLNH NHST, the body responsible for his placement, wished to place ASK) as to whether a transfer out if the IRC to hospital was necessary or appropriate .

178. On 20 May 2013 a further detention review was conducted. That recorded that, during the week leading up to the review, ASK had been stable and had been taking his medication. It indicates that his symptoms were manageable in the relatively short-term until a hospital place was found. It also records that, if he became manic then the healthcare team "might not be able to control [his symptoms]"; and, if this happened, then ASK would be found an acute bed, i.e. a bed on the equivalent of an "accident and emergency" admission. It was accepted that the administration of antipsychotic injections could only occur in hospital i.e. not in the IRC. The review specifically considered the application of Chapter 55.10 of the EIG; and concluded that, in the exceptional circumstances of the case and having been assured by healthcare staff that he was currently complying with his medication and his condition was manageable, detention should be continued.

179. On 22 May 2013, healthcare staff at Colnbrook IRC sought the assistance of Medical Justice, a charity established to provide independent medical and legal advice and representation to those detained in IRCs which receives about 1,000 referrals per year. The assistance sought was in respect of securing the ASK's admission to a suitable psychiatric unit. Medical Justice instructed Dr Charmian Goldwyn, another consultant psychiatrist.

180. Dr Goldwyn visited ASK on 26 May, and reported on 28 May 2013. She concluded that ASK was not fit to be detained, that it was imperative that he be transferred to a psychiatric unit as a matter of urgency, and that he lacked capacity to make decisions about his immigration situation or to instruct a lawyer. She identified specific benefits in a transfer, including better facilities necessary to manage aggressive behaviour and medication compliance including (if necessary) taking steps to enforce compulsory compliance. Dr Goldwyn thought that ASK might need compulsory treatment since he lacked insight into his mental illness and was currently not complying with medication offered to him in the IRC. She also thought that segregation distressed him and was likely to be causing a further deterioration of his mental health.

181. However, as I have already indicated, Dr Goldwyn's view was firmly contradicted the following day by Dr Morrison who concluded ASK did not require transfer to an acute psychiatric ward; and, although he would benefit from antipsychotic medication, Dr Morrison considered there was no justification to treat him against his will. On the basis of that report, Dr Khan (another of the psychiatrists at Colnbrook IRC) considered that ASK might be released into the community with the support of and supervision by the CMHT in supported hostel accommodation, where his mental health needs could be met.

182. On 30 May 2013, there was a further detention review. The caseworker, faced with conflicting clinical opinion, had written to the healthcare team on 23 May 2013 asking it to explain whether, in ASK's present state of health, there was any possibility that he could be released into the community if adequate and stringent safeguards were put in place. It also asked whether, if he could not be released into the community, at what point in time they would be able to effect his transfer under the MHA 1983. Leaving aside the risks that ASK posed, based on the medical evidence, three options were therefore in play, namely ASK (i) remaining in the IRC where his condition could and would be managed, (ii) being transferred to a hospital under section 48 or (iii) being released into the community on temporary admission in the hope that he

would voluntarily attend a hospital and/or in due course be detained under section 2 or 3 of the MHA 1983.

183. The prevailing view then taken was that ASK was stable, that his condition could be managed in the IRC whilst a bed was found and that the situation needed to be monitored and, it would seem, further clinical advice received. This was reflected in the record of the 11 June 2013 detention review, which recorded that ASK was (i) currently taking his medication, and (ii) unfit to fly "but fit to be detained as his symptoms are currently manageable by the healthcare team". They sought a further opinion from Dr Khan but in the interim recommended continued detention. An email that day from a caseworker (who was still trying to find ASK a hospital placement) described ASK as "stable and calm in mood and behaviour, he is compliant with all his prescribed medications no aggressive or violent behaviour has been observed". None of that, however, sits with the opinion of ASK's solicitor who visited him that day and found him to have been "extremely unwell". She had "no doubt he lacked capacity to bring proceedings" (Second Statement of Jane Ryan dated 20 May 2015, paragraph 2.3).

184. On 16 June 2013, on the basis of an assessment he conducted on 1 June, Dr Khan concluded that ASK was both fit for detention *and* fit to fly. On the basis of that assessment, on 19 June 2013, the Secretary of State referred him for removal on a charter flight to Pakistan on 9 July 2013.

185. However, on 19 June 2013, solicitors acting for ASK (but instructed through the Official Solicitor) challenged ASK's continuing detention. On 21 June 2013, ASK signed a consent form permitting the disclosure of his medical records to the Secretary of State (which were provided on 17 July 2013).

186. On 22 June 2013, Dr Khan reviewed the case and found ASK to be in a very different condition from that recorded on 1 June: he was "thought-disordered, non-compliant with medication, poor insight into his illness and medication" and he "may need inpatient admission".

187. On 2 July 2013, the Secretary of State received a fax direct from ASK saying that he wished to return home to Pakistan. The caseworker sought advice from healthcare as to whether ASK had the mental capacity to make that decision. On 3 July 2013, the IRC healthcare team responded saying that ASK had limited insight into his mental state and that this could impair his capacity.

188. There were, at this stage, two issues, both clinical in nature and indeed linked. First, there was the clinical disagreement over whether ASK required transfer from the IRC to hospital for treatment. Second, the Lakeside Unit having declined him, there was the issue as to where MDA would go, if he were hospitalised.

189. On 3 July 2013 at the request of ASK's solicitors, NHSE contacted the Secretary of State indicating that it was prepared to assist in resolving the problem over the availability of a bed within a psychiatric unit, given that Dr Morrison indicated that the Lakeside Unit was not prepared to accept ASK.

190. In parallel with that initiative, in an attempt to resolve the clinical disagreement over whether ASK required transfer to a hospital, Medical Justice on behalf of ASL

instructed a further consultant psychiatrist, Dr Andrew Dossett. Having seen him on 26 June 2013, in a report dated 6 July 2013, he concluded that ASK had a severe mental illness requiring management in a psychiatric hospital. He recommended discharge into the community for an urgent mental health assessment or treatment under sections 2 and/or 3 of the MHA 1983 or transfer pursuant to section 48. He certified that, as at the date of the assessment, ASK (not then on medication) lacked the mental capacity to instruct legal representatives. He differentiated between the mental capacity of ASK when compliant with his medication regime and when non-compliant, saying (in response to Question 4 in the certificate) that ASK might regain capacity to conduct proceedings in the future if he complied with his medication.

191. As recorded by Green J (at [142] of his judgment), in paragraph 124 of his statement dated 28 October 2015, Kiran East (who, in 2103, was the Senior Executive Officer in charge of the detained casework team located in the West London Removals Hub) gave an overview of the position as at 12 July 2013, as follows:

> "The steps which were being taken by the healthcare team to transfer [ASK] to hospital were effectively halted by the medical opinion of Dr Morrison to the effect that [ASK]'s condition did not warrant transfer to hospital under section 48 of the [MHA 1983]. For a short period thereafter the option of release into the community was explored but that was not clinically recommended unless there was agreement for provision of mental health support in the community from the responsible body, which was not forthcoming. There were no barriers to removal subject to fitness to fly at the point of departure and [ASK] wished to return to his home country. However, the appropriate progression of the case had to be informed by the clinical position, which required clarification."

192. The report of Dr Dossett was provided to the Secretary of State on 16 July 2013. On 18 July 2013, the Secretary of State confirmed that no steps would be taken to remove ASK pending his transfer to hospital. From that date, he accepted that ASK should be moved from the IRC into a psychiatric ward of a hospital.

Period 4: 18 July to 23 September 2013

193. On 24 July 2013, Dr Chabra, a consultant psychiatrist, felt unable to assess ASK because he was psychotic, and exhibiting florid formal thought-disorder. Dr Chabra confirmed that which the Secretary of State now accepted: ASK required transfer to a psychiatric unit for treatment. On 25 July 2013, on a further detention review, it was frankly said:

> "The healthcare team cannot enforce compliance and I think it arguable that he is reaching the stage where we cannot sensibly say that he can be satisfactorily managed per the policy set out in 55.10 EIG. All current medical evidence indicates this.
>
> But, even if that is the case I am still satisfied that there are, in accordance with this policy, very exceptional circumstances – essentially the absence of any other viable option – why we

> must maintain detention whilst we effect his transfer to hospital in accordance with the latest medical recommendations. It seems that the psychiatric assessment on 24 July 2013 has supported the view that the subject requires inpatient treatment and it is hoped that a bed will soon be available. We will know more tomorrow. I recommend continued detention."

194. That day (25 July 2013), ASK acting through the Official Solicitor issued the claim for judicial review together with an application for release from detention by way of interim relief.

195. In the meantime, on 15 July 2013, NHSE had recommended referral of the case to the WLMH NHST for consideration of transfer to a low/medium secure unit; and, on 26 July 2013, ASK was accepted for placement by that trust. A referral was made by the PICU to the Charing Cross Hospital. On 15 August 2013, the team at the WLMH NHST held a placement meeting. ASK was assessed by that unit on 19 August 2013.

196. On 21 August 2013, Charing Cross Hospital indicated that it accepted that ASK was suitable for admission and it indicated that it would send an assessment team to assess ASK on 11 September 2013.

197. The hearing for interim relief in the claim came before Mitting J on 10 September 2013; and he directed that ASK should be released into the community on 25 September 2013 unless he had been transferred to a psychiatric hospital.

198. ASK was admitted to the Low Secure Services Unit at St Bernard's Hospital on 23 September 2013 under section 48.

Factual Postscript

199. However, the following day (24 September 2013), the Secretary of State granted ASK temporary admission. ASK remained at St Bernard's. From 15 November 2013, he was detained there under section 3 of the MHA 1983.

200. There were several reports in respect of ASK's time at St Bernard's available below. On 5 December 2013 a report was prepared by Dr Nicholas Stokes, a Consultant Clinical Psychologist at St Bernard's Hospital. During interviews ASK was polite and courteous, but suffered from flight of ideas, fluctuating thought-disorder and a preoccupation with his period in detention which limited the scope of assessment possible.

201. Dr Stokes concluded that when ASK was most unwell his illness was characterised by thought-disorder, paranoid and grandiose thinking, verbal aggression, and sexual disinhibition and affective symptoms. The principal remaining symptom was thought-disorder which had improved over the course of the admission but continued to be prominent and significantly impacted upon his communication. A cognitive assessment indicated that his performance IQ on the Weschler Adult Intelligence Scale was in the extremely low range (1st percentile) which Dr Stokes considered was likely to be significantly lower than his pre-morbid level of ability and indicated a general cognitive decline which was secondary to his mental illness. ASK appeared to have poor insight into the nature of most of his past aggression and he displayed a

tendency to deny that incidents occurred or to have an external attribution for them. However, there had been no significant incidents of aggressive behaviour during his admission, and it seemed that the previous aggressive incidents had been confined to periods when ASK was more acutely unwell.

202. A further report was prepared by Dr Dent dated 15 January 2014. It is recorded that ASK had shown a good response to treatment with the anti-psychotic aripiprazole and Depakote; but, nonetheless, he remained profoundly thought-disordered at times, with a tendency to ruminate over the circumstances of his admission to Lakeside Hospital in 2012.

203. On 19 January 2014, a Social Circumstances Report was prepared by Margaret Modeste who concluded that ASK had improved in his mental health but still suffered from a thought-disorder. She noted that ASK had a diagnosis of paranoid schizophrenia but was presently stable and compliant with his treatment plan.

204. On 23 January 2014, the First-tier Tribunal (Mental Health Chamber) sitting at St Bernard's Hospital concluded that ASK could be discharged. The tribunal accepted that the patient currently suffered from a mental disorder (psychotic illness) of a nature, but not of a degree warranting detention. The tribunal was concerned that the patient's health would deteriorate upon discharge into the community, but ASK confirmed that he was prepared to remain informally as an in-patient and to cooperate with the clinical team. Discharge was deferred for one week to enable arrangements to be made for transfer to an appropriate unit for informal inpatient treatment followed by appropriate aftercare arrangements being put into place pursuant to section 117 of the MHA 1983. He was duly conditionally discharged on 30 January 2014.

205. However, on 23 February 2014, ASK was re-admitted to hospital under section 3 of the MHS 1983 having suffered a relapse in the community, triggered by alcohol and drug consumption. Various reports show that he remained very unwell. He was not taking his medication – which was still not compulsorily administered. It is recorded that ASK was "adamant" that he wished to return to Pakistan. He did not trust his solicitor, he was suspicious, lacked insight and adamantly denied the possibility of mental disorder. He also firmly rejected the need for medication. A memo dated 5 June 2014 stated:

> "... it seems that [ASK] wants to be transferred back to the [IRC] because he thinks he will get deported back to Pakistan much faster from there rather than from the ward. Dr Maier explained to him that if he were in his situation, he would prefer to stay on the ward as the conditions in the detention centre can be difficult. Care plan: (1) Staff to assist him in getting additional clothing. (2) Dr Maier will contact his solicitor to explore options of transferring him back to detention centre and/or Pakistan. (3) Team will liaise with his SW regarding the above. (4) Team to contact Pakistani embassy regarding necessary passport/travel documents. (5) Explore available options for therapeutic activities while he remains on the ward. (6) Continue to encourage him to comply

> with his medication and refrain from cannabis use. (7) Continue to monitor mental state."

206. A record dated 30 June 2014 entered by Dr Maier, a consultant psychiatrist, recorded that ASK's brother expressed the view that his "best interests would not be served by returning to Pakistan". It is stated that the brother explained that there was mental illness on both sides of the paternal family and that the brother wished ASK to remain in hospital and not be returned to the IRC and/or removed to Pakistan.

207. A note of 29 July 2014 recorded that ASK had refused to accept medication for several weeks. He had become challenging and intimidating. The refusal to take medication is also recorded on 13 August 2014. However, an entry dated 26 August 2014 recorded that ASK had experienced a settled week. Dr Kamal concluded that he seemed better, and the plan was to transfer him to Mott House with eventual removal to Pakistan.

208. On 23 September 2016, ASK was conditionally discharged.

209. However, on 2 October 2016, he was arrested for indecent exposure and assault, and was remanded in custody where he stayed until 5 May 2017 when he was convicted and given an absolute discharge. From May 2017, he has received assistance from the London Borough of Hounslow under the Care Act 2014 and community mental health support.

210. He applied for further leave to remain, which the Secretary of State refused on 18 April 2018. His appeal to the First-tier Tribunal (Immigration and Asylum Chamber) is listed for hearing on 13 August 2019.

The Grounds of Appeal

Introduction

211. I set out the grounds of appeal upon which Ms Harrison relies above (paragraph 9). She relies upon particular grounds for each of the four periods she identified, together with some grounds which apply throughout the whole period of detention or at least for overlapping periods of it. As Ms Harrison did in her submissions, I will deal first with the grounds specific to the particular periods; and then turn to the more general grounds.

Period 1: 17 to 31 January 2013

212. Although for the period to 13 April 2013, Ms Harrison relied mainly upon the submission that the Secretary of State misapplied his own policy, for the period from 17 to 31 January 2013, she contends that he failed to consider that policy at all; and, if he had done so and applied it properly, ASK would never have been detained. In support of that submission, she relied upon the fact that, until the handwritten note and detention review record of 31 January 2013 (quoted at paragraph 162 above), there is no reference in any of the documents to either Chapter 55.10 of the EIG, or any of its terms or criteria, or of the possibility of ASK's mental condition being such that he might need to be released. There is no evidence of the Secretary of State

considering the policy or the issues it raises until that date. In not considering his own relevant policy, he erred in law.

213. However, I am unpersuaded. ASK's leave to remain expired on 30 October 2012. At [169] of his judgment, Green J concluded that, as at 17 January 2013, ASK "was an obvious candidate for removal but also presented as a risk of absconding given that he had no address to be contacted at and was unwilling to engage with immigration services"; so that "the immigration authorities had a *prima facie* right to detain him in an IRC subject only to the issue of his mental health". As Ms Harrison frankly accepted, those were findings properly open to the judge. In relation to risk of absconding (which "is of critical and paramount importance in the assessment of the lawfulness of the detention" (see Fardous at [44], quoted at paragraph 45(ii) above), that did not materially change over the period of his detention. Again, Ms Harrison does not suggest otherwise.

214. Green J dealt with the medical position as at 17 January 2013, in considerable detail and with care, at [168] onwards in his judgment. It was clear that those who assessed him as the time were in touch with the Lakeside Unit, and were aware that he had a recent history of mental health problems and that he had recently been discharged from the hospital and then discharged under section 117 (see [177]): discharge under section 117 can only take place when both clinicians and social services are satisfied that the patient concerned is no longer in need of such services (see paragraph 29(ii)). As Green J properly said (at [171]), the clinical view at the time (e.g. that of Dr Sultan on 19 January 2013: see paragraph 158 above) was that, although ASK was suffering from mental health problems, they could be managed in detention and did not warrant immediate transfer to hospital: and, therefore, Chapter 55.10 of the EIG was not applicable (see paragraph 47 above). That clinical view was a perfectly reasonable one, and appears to have been unanimous during the whole of this period; and it was clearly reasonable for the Secretary of State to adopt it.

215. ASK's initial detention was therefore not unlawful on this ground; and nothing occurred before 31 January 2013 to change that position. His short-lived transfer to Morton Hall IRC clearly did not do so: that IRC did not have the same medical facilities as Colnbrook and, when it seemed that his symptoms could not be controlled at Morton Hall, he was quickly transferred back. There was no evidence then that his condition would not be managed at Colnbrook IRC.

Period 2: 31 January to 13 April 2013

216. Ms Harrison accepted that, from 31 January 2013, the Secretary of State had in mind and purported to apply his policy as set out in Chapter 55.10; but, she submitted, he misunderstood and misapplied that policy in two respects.

217. First, he proceeded on the basis that an illness that can be "satisfactorily managed within detention" is the antithesis of an illness that requires hospitalisation, so that an individual with a mental illness can lawfully be detained so long as he does not require treatment in hospital. Green J agreed with that interpretation. Ms Harrison submitted that he was wrong to do so: he fell into the same error as the error into which Sales J (as he then was) fell in Das (see the judgment of this court in Das at [60]).

218. However, I do not find this ground to be sound, for these reasons.

i) As Sir James Eadie forcefully pointed out, the passage of Das at [60] upon which Ms Harrison relies gives no real support to her submissions. It concerned with "what constitutes a serious mental illness" (see [60]), i.e. the meaning and scope of "serious mental illness". Sales J had equated it with an illness which requires in-patient treatment in hospital or liability to being made subject to section 3 of the MHA 1983 or a risk that detention will reduce the detainee to such a state. It did not concern the scope of the policy, i.e. what falls within the scope of "serious mental illness *which cannot be satisfactorily managed within detention*" (emphasis added).

ii) If mental illness can be as well managed in detention as elsewhere, then it seems to me that that will necessarily mean that it can be "satisfactorily managed within detention".

iii) However, it may be that, in the phrase used by Dyson LJ in M (quoted at paragraph 59 above), the illness "will require treatment elsewhere". It may require admission to hospital; but, as Beatson LJ pointed out in Das (at [63]), some mental illnesses are exacerbated if the patient is placed in hospital; and many of those with serious mental illnesses (including schizophrenia) not only can be, but are best, treated in the community.

iv) However, in ASK's case, in practice treatment in the community was not a realistic possibility, because of his tendency to use drugs and not to comply with his medication, e.g. in January 2014, within days of being conditionally discharged by the FtT, ASK was readmitted to hospital under section 3 of the MHA 1983 having suffered a relapse as a result of alcohol and drug consumption. That tendency was apparent from January 2013. In 2013, the generally held view was that, if ASK could not be satisfactorily managed in an IRC then he required hospitalisation. Hence the contemporaneous focus upon a hospital direction under section 48 of the MHA 1983.

v) In the circumstances, I do not consider either the Secretary of State or Green J erred in their focus on whether ASK's illness was such as to require hospitalisation.

219. Second, Ms Harrison submitted that, in any event, the Secretary of State interpreted "satisfactorily managed" too widely. A serious mental illness could not be "satisfactorily managed within detention" if it deteriorated, or if there was a risk that it would deteriorate, or if there was a treatment outside detention which might result in an improvement in the condition (see O at [30] per Lord Wilson JSC). In ASK's case, she submitted that his illness did deteriorate, e.g. when he was sent to Morton Hall IRC (see paragraph 159 above), and when he refused to take his medication (see paragraphs 168 and 170 above); and, certainly, there was a risk of deterioration throughout this period. Furthermore, hospitalisation promised an improvement in his condition, because medication compliance would be better, by way of injection and/or forcibly administered medication if necessary.

220. However, again I am unpersuaded.

i) The policy refers to "those suffering serious mental illness which cannot be satisfactorily managed within detention". The focus is therefore upon management of the serious mental illness. Such illnesses by their nature can, without deteriorating as an illness, be variable in symptomatology over time; and clinicians can, quite reasonably, differ in their assessment of diagnosis, prognosis and the severity of the symptoms of which complaint.

ii) In my view, Ms Harrison sought to give a precision to the scope of "serious mental illness which cannot be satisfactorily managed within detention" which is both unwarranted and illusory. The cases upon which she relied do not suggest that such precision should be sought. Indeed, as Lord Wilson said in O at [30], "satisfactory" in this context is "a word of extreme and appropriate elasticity", which "catches a host of different factors to which the circumstances of the individual case may require her to have regard". Therefore, when the Secretary of State is assessing whether a particular serious mental illness can be satisfactorily managed in a particular patient in an IRC, so long as his approach to the assessment is lawful he necessarily has a wide margin of discretion.

iii) In making that assessment, although the Secretary of State cannot abdicate his statutory and public law responsibilities, where conscientious enquiries have been made about the health of the detainee in in the context of Chapter 55.10 of the EIG, then he is generally entitled to rely on the opinion of the clinicians or, if opinion is not unanimous, to rely upon any one of the opinions insofar as it appears sincerely and reasonably held.

iv) Whether an illness has deteriorated, or whether there is a risk that it will deteriorate, will clearly be an important fact in this assessment – indeed, I accept that it may usually be critical – but I do not accept that it will be necessarily decisive. Certainly, Lord Wilson did not consider that the availability of treatment that might effect a positive improvement in the individual would be determinative (a point expressly left over by Beatson LJ in Das at [71]). Lord Wilson merely said that "its availability should go into the melting-pot". That again emphasises the open-textured nature of the assessment involved.

v) In any event, I am unable to accept Ms Harrison's submission that any deterioration in the symptomatology of the detainee or even risk of such deterioration – no matter how small, and how transient – is sufficient to show that the detainee's illness cannot be satisfactorily managed in detention. It is wrong to take such a snapshot of the illness. As Beatson LJ said in VC at [65], "periods of calm are not necessarily indicative… of a mental health condition being satisfactorily managed…"; but, in my view, the opposite is also true. A conclusion that an illness cannot be satisfactorily managed in detention cannot be drawn from merely the fact that there is an increase in severity of symptoms. It may be that that increase is just a manifestation of a variable condition; or that a change in medication will reduce the symptoms again, and such a change would be well within the scope of satisfactory management of the condition. The crucial question is a broader one, namely, as put by Dyson LJ in M at [39], "whether facilities for treating the person whilst in detention are available so as to keep the illness under control and prevent suffering" (i.e.

suffering that would not have to be endured if the individual was being treated out of detention).

vi) However, the Secretary of State cannot shut his eyes to the variations in a person's condition as reflecting his illness by failing to monitor the individual's condition thereby risking a deterioration to a point where the illness cannot be managed. Therefore, at least on initial detention and at the regular detention reviews, there is an obligation on the Secretary of State to be alert to signs of (e.g.) deterioration that indicate the illness is not being satisfactorily managed (R (BA) v Secretary of State for the Home Department [2011] EWHC 2748 (Admin) at [183]-[184] as approved in VC at [52]). Wherever a detainee has a serious mental illness, Chapter 55.10 is engaged to that extent.

221. Green J concluded that the Secretary of State at all times made the assessment as to whether ASK was fit to be detained "in accordance with the relevant policy", included whether his mental condition "could be satisfactorily managed in the IRC and/or whether it could be better managed in hospital" (see [9(iv)-(v)]). He expressly found that, at all relevant times, the case workers "were asking themselves the relevant questions and had Chapter 55.10 EIG well in mind… [including] the issue in [O] namely whether [ASK] would be better treated elsewhere, such as in hospital…" (see [176]).

222. On the evidence, those were clearly findings the judge was entitled to make; indeed, a review of the evidence for this period set out at paragraphs 163-170 above makes clear that those findings were inevitable, the case workers usually working directly to the criteria set out in Chapter 55.10. For example, in the detention review on 14 March 2013 (see paragraph 168 above), having considered the medical evidence, the case worker concluded that it clearly demonstrated that ASK's illness was being satisfactorily managed in detention. As Green J found, it is impossible to say that the Secretary of State was not entitled to come to that conclusion throughout this period.

223. Ms Harrison made a particular point concerning the review of ASK by Dr Sultan on 9 February 2013 (referred to in paragraph 164 above). She submitted that Dr Sultan then, for the first time, concluded that ASK was not fit to fly; and the Secretary of State should then immediately transfer him to hospital. However, as Green J said (at [180]-[181] of his judgment, that review has to be seen in context; and, at that stage, Dr Sultan considered ASK fit to be detained and it is clear that the clinicians had not found that ASK would not be fit to fly in a reasonable time even if he remained being treated in detention. Indeed, when Dr Sultan next reviewed ASK on 23 February 2013, his condition is recorded as having improved (see paragraph 165 above). On 7 March 2013, removal directions were said to be "very" imminent (see paragraph 166 above). There is nothing in this discrete point, which fades into the reasons for challenging ASK's detention for the period after 13 April 2013.

Period 3: 13 April to 18 July 2013

224. On 13 April 2013, Dr Sultan recorded that ASK was not fit to be detained. That was the first expression of that opinion by a clinician. Ms Harrison submits that, from that date, there was no real prospect of ASK being removed within a reasonable time, and he ought to have been transferred immediately to hospital or alternatively simply

granted temporary admission. In continuing to detain him, the Secretary of State breached her own, Chapter 55.10 policy – as well as the common law principles in Hardial Singh.

225. Green J (at [182]-[187] of his judgment) said that the 13 April 2013 review has to be seen in its full factual context. I agree.

226. Dr Sultan made a hospital referral to the Colne Ward on 24 April 2013. As I have described (see paragraphs 173 and following), it was made under section 48 of the MHA 1983: Dr Sultan did not consider there was any real prospect of discharging ASK into the community. ASK was seen by Dr Musah of the Colne Ward on 8 May 2013, who agreed he should be transferred to a hospital – but the Colne Ward had no space for him. A place at the Lakeside Unit was sought. He was, properly, referred to the WLMH NHST, who were responsible for finding a place for him. By 12 May 2013, the two required reports for admission had been completed; but neither was by a doctor from the receiving hospital. In the event, on 15 May 2013, Dr Morrison of the Lakeside Unit declined the referral, on the basis that ASK did not need an acute hospital place. There then followed a disagreement between clinicians as to whether ASK required transfer from the IRC, and also some efforts into finding him a place if he did. That was not resolved until the intervention of Medical Justice and Dr Dossett's "tie-breaking" opinion that he required management in a psychiatric hospital. That was communicated to the Secretary of State on 16 July 2013; and he accepted that recommendation on 18 July 2013.

227. In my view, it is impossible to say – as Ms Harrison submits – that the Secretary of State acted unreasonably or unlawfully during this period.

i) Once the Secretary of State has reasonable grounds to believe that a detainee requires treatment in hospital because his illness cannot be satisfactorily managed in detention, he is under a duty "expeditiously to take steps to obtain appropriate medical advice" (R (D) v Secretary of State for the Home Department [2004] EWHC 2857 (Admin) at [33] per Stanley Burnton J).

ii) As I have explained, the decision to admit a patient to a hospital is a ultimately a clinical decision which the Secretary of State cannot override: he cannot require a hospital to admit a patient.

iii) Although the Secretary of State had a continuing obligation to act with reasonable expedition, once Dr Sultan had concluded that ASK was unfit to fly and should be transferred to a hospital under section 48, the matter fell into the hands of the health authorities (notably the WLMH NHST, which was responsible for finding ASK a hospital place). The Secretary of State did nothing to delay the process.

iv) The initial delay was because the hospital to which ASK was referred (the Colne Ward) had no place.

v) The overwhelming reason for the delay thereafter was the difference in clinical views as to whether ASK in fact required transferring to a hospital at all. Crucially, Dr Morrison (at the Lakeside Unit, to where ASK was next referred) on 29 May 2013, and Dr Khan on 1 and 16 June 2013, considered a transfer to

a hospital was not appropriate on clinical grounds. As Green J said (at [183] of his judgment), they had direct experience of ASK, and were well qualified to express that opinion. Ms Harrison does not suggest otherwise; nor does she suggest that the opinions given were not sincere and reasonable. On the other hand, Dr Musah on 8 May 2013, Dr Sultan on 11 May 2013 and Dr Goldwyn on 26 May 2013 were all of the view that he should be urgently transferred to a hospital. Again, Sir James Eadie did not suggest that those clinical opinions were anything other than sincere and reasonably held.

vi) In my view, the Secretary of State did not arguably act unlawfully during this period. First, he was entitled to rely upon the opinions of Drs Morrison and Khan. He was also entitled to treat the opinion of Dr Dossett as an effective tie-breaker; and, once his opinion to the effect that ASK should be transferred to hospital, to be persuaded by that. However, second, in fact, the Secretary of State did nothing to hamper the transfer of ASK after Dr Sultan's initial opinion on 13 April 2013, the delay being caused by a genuine dispute between the clinicians as to whether ASK should be transferred.

vii) Ms Harrison relied upon the GPPG, in which the Department of Health set out guidance for the time frame in which transfers from prison/detention to a hospital should take place (quoted at paragraphs 22-24 above. It suggests that from first medical report to final warrant should be perhaps a couple of weeks. It suggests that "differences of clinical opinion" should not "stop the clock". Here, it was several months. However:

a) This is mere guidance, and in any event it does not necessarily cater for exceptional cases.

b) Although it refers to "differences in clinical opinion" not stopping the clock, it does not detract from the fact that the Secretary of State has a power, not a duty, to transfer. In a clinically difficult case – especially where, as here, the clinical differences related to whether the patient should be transferred to hospital or remain in the IRC – he is not bound to accept the first clinical opinion that he receives, and was entitled in this case to be unconvinced that ASK should be transferred until Dr Dossett's opinion to that effect.

c) Once he had accepted Dr Dossett's advice, the Secretary of State acted promptly (within two days) in pursuing a transfer.

viii) Ms Harrison also relied upon the fact that, for any section 48 transfer, it is a requirement that the detainee "is in urgent need of treatment" (section 48(1)(b) of the MHA 1983). She submitted that this required the Secretary of State to ensure an "urgent" transfer. However, "urgency" is a relative concept. Green J specifically considered this issue (at [190]-[192] of his judgment). He found that "there is no evidence that during this period the condition of ASK deteriorated or reached such an acute stage than an ***immediate*** transfer was required" (emphasis in the original). Healthcare resources are scarce, and seriousness of condition is a relative concept; and, he said, case workers were aware that, if he did deteriorate, then he could be taken to A&E in which case, if required, a bed would be found for him in that context. In the meantime, he

said, ASK was being monitored and treated in the IRC. He consequently found that the delay caused in transferring ASK because of the clinical disagreement or a shortage of capacity was not such as to give rise to a breach of duty. That reasoning, and the judge's conclusion, is unimpeachable.

ix) Insofar as Ms Harrison submitted that, during this period, the Secretary of State was not detaining ASK for the proposes of removing him, but rather pending transfer to a hospital, I deal with the issue of principle below in relation to the next period; but, in addition, in this period, there were times when a clinician considered ASK was fit to fly (see paragraph 184 above: Dr Khan expressed that view based on an interview on 1 June 2013, and removal directions were fixed for 9 July 2013 on that basis).

228. For those reasons, I consider that, during this period, the Secretary of State neither failed to comply with his own policy nor did he unreasonably detain ASK under the Hardial Singh principles

Period 4: 18 July to 23 September 2013

229. By 18 July 2013 the Secretary of State had accepted that ASK's transfer out of an IRC into a hospital should be made. As a result of Dr Dossett's report dated 6 July 2013 received by the Secretary of State on 16 July 2013, Green J found (at [185] of his judgment) that "detention with a view to removal was no longer a possibility". That, in effect, was a finding that removal within a reasonable time was not possible; and ASK continued to be detained, not pending removal from the UK, but pending transfer to hospital. There is no power to detain in those circumstances, even if detention is ostensibly for the benefit of the detainee (R (AA) v Secretary of State for the Home Department [2010] EWHC 2265 (Admin) at [40] per Cranston J).

230. However, even when the Secretary of State is satisfied that a detainee should be transferred to hospital – as he was in ASK's case from 18 July 2013 – he is not required to release him from IRC forthwith. He is then under a duty expeditiously to take reasonable steps to ensure the detainee is transferred to hospital for assessment and/or treatment (R (HA (Nigeria)) v Secretary of State for the Home Department [2012] EWHC 979 at [171] per Singh J as he then was). In the course of debate, Ms Harrison accepted that the Secretary of State would have to be given some time to arrange a transfer; but submitted that that time must be short. She relied upon HA (Nigeria) in which, on the facts of that case, Singh J said that:

> "Although such arrangements cannot necessarily be made overnight, or even within a few days, on any view, the delay of over five months in this case was manifestly excessive."

231. In my view, even where the Secretary of State is satisfied that, because of the requirement for treatment in hospital, there is no real prospect of removing the detained person within a reasonable time, the Secretary of State is not bound immediately to release the person into the community to fend for himself and/or in the hope that he might (voluntarily) attend hospital or do something to provoke an order under section 2 or 3 of the MHA 1983. The person is still liable to be removed; and, in the circumstances of this case, in my view it is open to the Secretary of State to keep a person detained and safe for a reasonable time pending transfer to a hospital

(initially under section 48 or by some other mechanism) even in circumstances in which, if he were to remain in an IRC without the prospect of such transfer, the Hardial Singh principles might be breached. That does not seem to me to be a wrong or abusive use of the power to detain under the Immigration Acts; and the argument that it *is* wrong or an abuse seems to me to cast the Hardial Singh principles too rigidly.

232. Green J adopted this approach. He found (at [9]):

> "(ix) The delays which occurred thereafter in effecting the physical transfer of ASK to hospital were due to (a) potential receiving hospitals wishing to carry out their own assessments of ASK and/or (b) problems in locating a suitable hospital bed. These were delays intrinsic to the system. In all the circumstances they were neither excessive nor unreasonable.
>
> (x) During the period during which ASK was awaiting transfer his condition did not deteriorate. There is no evidence to support the contention that the treatment available in hospital was materially more beneficial to ASK than that which was provided in the IRC. Although it involves the use of hindsight the chronology post-dating transfer to hospital does not show either improvement or deterioration in ASK's condition."

His more detailed consideration is at [188] and following.

233. In particular, the judge found that, in all the circumstances of the case, the Secretary of State was not required to treat the case as "one of such compelling and overriding urgency that a hospital bed needed to be secured forthwith, i.e. immediately" (see [188]). It was an obligation on the Secretary of State to consider the level of urgency; but it was of course driven by medical opinion. At no stage, as a matter of clinical judgment, did ASK's medical condition require immediate transfer to hospital. ASK was regularly seen by (amongst others) those from units to which it was hoped he would be transferred. If any had considered his immediate transfer necessary, they would no doubt have said so and it would have been arranged. Allocation and prioritisation of sparse healthcare resources were, the judge found, a relevant criterion for the health service providers to take into account (see [191]-[192]). The judge found that, if that circumstance came about suddenly and unexpectedly, caseworkers at the IRC were aware that they could have prompted a decision to identify a hospital bed immediately by attending a hospital's Accident and Emergency Unit (see [192]). In the meantime, he found that it was both proper and reasonable for prospective units that might admit ASK to perform their own assessment of him to ensure that their unit was appropriate for him (see [188]).

234. I understand that ASK would have preferred to have been admitted to a hospital more quickly; but the judge adopted the right legal approach, he took into account the complex character of his condition, and the evidence as to why it took several weeks. I am simply unable to say that his conclusion that the time taken to transfer ASK was not unreasonable was wrong.

Articles 3 and 8 of the ECHR

235. In addition to the grounds of appeal which focused on particular periods of detention, Ms Harrison also relied upon grounds that applied throughout the whole period of ASK's detention.

236. First, she submitted that Green J materially erred in his approach to article 3 by:

i) applying the wrong legal test for the severity threshold, namely by adopting the criteria set out by Lord Bingham in Drew at [19] as if they were prescriptive;

ii) coming to a legally perverse conclusion that article 3 was not breached, in the light of the evidence that segregation was used to manage his mental illness and the delay in transfer to hospital contributed to his lapse into psychotic illness ;

iii) failing to give adequate reasons for that conclusion; and

iv) failing to consider the positive duties to prevent a breach of article 3.

237. However:

i) Drew was a case of a mentally ill defendant who was denied medical treatment in hospital which his condition required, which resulted in severe symptoms for eight days and months entirely to resolve (see [4]). It was held that article 3 was not engaged. The circumstances of this case are sufficiently similar to make the criteria set out by Green J in [33] of his judgment apposite:

> "For a violation of article 3 to arise there must therefore be: (a) a denial of medical treatment which is available in hospital; (b) which is of a nature which the person's mental condition requires; (c) where evidence exists that the person concerned suffered serious consequences as a result of the denial; (d) a failure to exercise a transfer power to hospital 'promptly'; and (e) the consequences suffered by the person in question reach a level of 'sufficient severity' to engage the operation of article 3. These conditions are expressed in Drew as being cumulative."

In any event, Green J simply took those conditions as a marker: he went on (in [34]) to set out the summary of the relevant law from HA (Nigeria), which Ms Harrison accepts is a helpful and true summary of the appropriate principles. Green J clearly approached the issue of legal threshold for article 3 correctly.

ii) As I have described, Green J concluded that the Secretary of State at all times made the assessment as to whether ASK was fit to be detained "in accordance with the relevant policy", included whether his mental condition "could be satisfactorily managed in the IRC and/or whether it could be better managed in hospital" (see [9(iv)-(v)]). He expressly found that, at all relevant times, the case workers "were asking themselves the relevant questions and had Chapter 55.10 EIG well in mind… [including] the issue in [O] namely whether [ASK]

would be better treated elsewhere, such as in hospital…" (see [176]). Given those findings, and Green J's comprehensive consideration of all the evidence, I find it impossible to find that his conclusion that article 3 was not breached was wrong. Whilst segregation does not appear to have been at the forefront of the hearing before Green J, (a) there is no evidence that it was used as a punishment or to manage his medical condition as opposed to its legitimate purposes under rule 40; and (b) as opposed to the general proposition that segregation can give mentally ill patients adverse effects, there is no evidence that ASK himself suffered at all by virtue of being segregated. Similarly, there is no evidence that suggests that the use of rule 41 force on ASK resulted in any harm or indignity to him which, even with the other aspects of his detention, reached the article 3 threshold level.

iii) In terms of reasons, it is true that Green J did not express his reasons as to why he considered there was no breach of article 3 at any great length: but, having set out the correct legal approach and the evidence, in my view they were sufficient. He concluded that, in all the circumstances (which he set out), the suffering of ASK in detention was not such sufficient to cross the article 3 threshold. That conclusion was not only open to him on the evidence, in my view it was correct.

iv) Ms Harrison criticises the judge's failure to consider the positive duties imposed by article 3 to be proactive and prevent a breach occurring. However, his findings in relation to the management of ASK's condition point against a "wait and see" approach; and, in any event, in my view he was correct to find there was in fact no breach of article 3 here. There was certainly no material breach of the positive duties imposed by article 3.

238. Ms Harrison made no distinct submissions in relation to article 8.

239. For those reasons, I would dismiss this ground of appeal.

Mental Capacity and the EA 2010

240. Ms Harrison relied upon the ground made good in VC and in MDA's case, namely that the Secretary of State, having reason to believe that ASK may have been incapacitous, breached the common law duty of fairness by not enquiring into that capacity; and similarly breached the PSED by failing to make sufficient enquiries to gather necessary information to enable him to take into account ASK's disabilities in the context of the decisions to detain and to continue to detain him. In ASK's case, there was a sufficient trigger for those duties, in that he had been the subject of mental health intervention shortly before he was detained in January 2013 – and the evidence of his lack of capacity simply increased during the course of his detention. ASK was therefore entitled to a declaration that the Secretary of State breached the PSED. In addition, Ms Harrison submitted that, by failing to make reasonable adjustments to the decision-making processes, the Secretary of State breached sections 20 and 29 of the EA 2010; and ASK was entitled to a declaration to that effect in the same terms as was made in VC (see paragraph 133 above).

241. Sir James Eadie, of course, accepted the purport of VC; but submitted that, in this case, Green J identified the correct issue (at [65]-[69] of his judgment) but went on to

find that ASK's mental capacity was in fact considered by the healthcare professionals who saw his regularly. He said:

> 198. The second point to observe is that on the facts ASK's mental capacity was under constant review by an array of qualified professionals who were aware of his personal circumstances and were constantly considering what the best treatment for him was and whether it could be provided in the IRC. I can see no evidential basis for saying that yet another clinician instructed solely to act on ASK's behalf and acting with professional objectivity would have altered the situation.
>
> 199. Third, evidence that ASK's capacity was in the minds of the decision-makers is found in the acceptance by the Defendant of the conclusion in the report of Dr Dossett that when ASK is non-compliant with his medication regime he lacks capacity, but when he is compliant he has capacity. As of the date of this report ASK himself wished to return to Pakistan (see paragraph [138] above). Yet, acting in ASK's best interests, and upon evidence that he might lack capacity, the Defendant decided that contrary to ASK's personal preference in his best interests no steps should be taken to remove ASK (see paragraphs [139] – [143] above).
>
> 200. In these circumstances I can detect no breach of the MCA 2005. In the alternative if there was a breach it caused no loss or damage or prejudice to ASK."

242. In the circumstances, Sir James submitted that, in refusing ASK the declaration he claimed, Green J was not wrong.

243. That was a bold submission, but I am afraid I am unable to accept it. Green J, without the benefit of the judgment of this court in VC, focused on whether the various decision-makers on behalf of the Secretary of State had the best interests of ASK in mind. However, as VC makes clear, that is not the point: ASK had the right to participate in the decision-making process, including challenges to decisions that were made in respect of him in relation to his detention, segregation and (importantly in his case) transfer to hospital. In my view, it matters not that many of the decisions did not require ASK's consent: he was nevertheless entitled to participate in them in the form of representations.

244. In my view, in this regard, ASK's case is not materially different from the cases of VC or MDA. Because of his illness, ASK suffered from a disability. It seems likely that, from time-to-time, he lacked the capacity properly to engage with the detention authorities in relation to important decisions that related to him, e.g. with regard to his continuing detention, segregation and non-transfer to hospital. In those respects, he was treated differently from those detainees who were not disabled. In breach of the PSED, the Secretary of State failed to have due regard to the duty to eliminate discrimination. Further, the duty on the Secretary of State to make reasonable adjustments having arisen, no adjustments were made and obvious adjustments (e.g. in the form of IMCA-type representation) could have been made. The burden was

therefore on the Secretary of State to show he had complied with the duty to make such adjustments; and he adduced no evidence that he had even considered such adjustments and certainly no evidence that he had complied with the duty.

245. On this ground, subject to any submission on the precise formulation of the declaration, I would allow the appeal and grant a declaration that, in failing to have regard to ASK's disability, the Secretary of State breached the PSED; and that he discriminated against ASK by failing to make reasonable adjustments to the decision-making processes in breach of section 20 and 29 of the EA 2010. As with MDA's case, I would remit the damages claim for the breach of sections 20 and 29 to the county court.

ASK: Conclusion and Disposal

246. Therefore, as with MDA's case, subject to my Lords, I would allow ASK's appeal on the EA 2010 ground; and, subject to submissions on its precise form, make the declarations to which I have referred in paragraph 245 above. In relation to any claim for damages in relation to the breach of sections 20 and 29 of the EA 2010, I would remit that to the county court. Otherwise, I would dismiss his grounds of appeal.

Lord Justice Peter Jackson:

247. I agree.

Lord Justice Longmore:

248. I also agree.