Neutral Citation Number: [2014] EWHC 3257 (Admin)

Case No: 9057/2011

IN THE HIGH COURT OF JUSTICE

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/10/2014

Before:

MR JUSTICE HADDON-CAVE

- -

Between:

THE QUEEN ON THE APPLICATION OF DK	**Claimant**
- and -	
SECRETARY OF STATE FOR THE HOME DEPARTMENT	**Defendant**

- -
- -

Paul Bowen QC and Michelle Knorr (instructed by **Wilson LLP**) for the **Claimant**
Julie Anderson (instructed by **Treasury Solicitors**) for the **Defendant**

Hearing dates: 18th & 19th June 2014

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Approved Judgment

MR JUSTICE HADDON-CAVE:

INTRODUCTION

1. This is a claim for damages for unlawful administrative detention. The Claimant, a Turkish national, was detained by the immigration authorities from 10 December 2010, when his prison sentence expired and a deportation order was made, until 21 October 2011, when he was released on bail. The Claimant challenged his deportation on Article 3 ECHR grounds and was granted refugee status on 14 September 2012. By these proceedings, the Claimant claims that his immigration detention for this period of over 10 months was unlawful because of his mental condition and amounted to the tort of false imprisonment, for which he claims he is entitled to more than nominal damages.

Grounds of challenge

2. The Claimant challenges the lawfulness of his detention on two main grounds:

   (1) First, the Secretary of State failed lawfully to consider, or apply, her policy in Chapter 55.10 Enforcement Guidance and Instructions ("EIG") (regarding the detention of persons with serious mental illness that cannot be satisfactorily managed in detention), both at the outset of detention and thereafter at the time of periodical reviews.

   (2) Second, the Secretary of State breached Articles 3 and 8 ECHR and s 6(1) of the Human Rights Act 1998 (HRA) in respect of the Claimant's detention because the Claimant was suffering at the time from a serious mental illness of which the Secretary of State was, or ought to have been, aware and failed to take the steps reasonably available to her, by either providing suitable treatment or releasing the Claimant from detention.

3. The Claimant seeks (i) a declaration that the Claimant's detention was unlawful; (ii) a declaration that the Claimant's Article 3 and 8 rights have been breached, contrary to s 6(1) HRA; and (iii) damages for false imprisonment and under s.8 HRA in respect of the breach of Articles 3 and 8 ECHR.

Administrative Court list

4. The rules provide that claims for damages alone may not be brought in the Administrative Court: see CPR 54.3(2) (which provides "*a claim for judicial review may include a claim for damages … but may not seek such a remedy alone*") and *R(D) v Home Office* [2006] 1WLR 1003 at [58] and [105]. The claim for a declaration that the past detention was unlawful adds nothing to the claim for damages. The claim for judicial review was lodged on 22 September 2011, *i.e.* whilst the Claimant was in detention and shortly before his release. Following his release, there was an application for the matter to be transferred to the Queen's Bench List. However, exceptionally, this case was allowed to remain in the Administrative Court list because of the legal issues raised.

5. I nevertheless draw attention to the following pertinent general observations of Dingemans J in *Swaran v. SSHD* [2014] EWHC 1062 (Admin):

> "The Administrative Court seeks to make speedy decisions about the legality of administrative decision-making. The Administrative Court is heavily listed and should not become clogged up with what are, in reality, claims only for damages for wrongful detention within the jurisdiction of the Queen's Bench or County Court. The procedures of the Administrative Court are, in any event, not best suited to determine contested historic events where disclosure and cross-examination of witnesses may be necessary."

THE FACTS

6. The Claimant claims damages in tort for the whole period of his immigration detention from 10 December 2011 to 21 October 2012. The claim divides the detention into two periods: from 10 December 2010 to 19 May 2011 ('the First Period') and from 20 May 2011 to release on 21 October 2011 ('the Second Period'). The date of 19 May 2011 was selected on the basis that, from that date, express reference was made to the Claimant's mental health in the monthly detention reviews.

7. The following lengthy summary of the facts was drawn up and agreed by Counsel. It is to be queried whether a 14-page summary of the facts is either necessary or proportionate in a case such as this. It would not be a sensible use of court time, however, to attempt to cut it down.

8. The Claimant was born on 5 May 1972. He is a national of Turkey and is of Kurdish ethnicity.

9. On 12 February 2000, the Claimant arrived in the UK from Turkey *via* Germany and claimed asylum upon arrival. The Claimant indicated that he had come directly from Turkey. Checks were made and the German immigration authorities informed the Secretary of State that the Claimant had entered Germany on 11 October 1992 and was given leave to remain there until 19 November 1999. On 4 November 1999 the Claimant had claimed asylum in Germany but had left before the claim was decided. The German asylum claim was refused on 17 March 2000, after the Claimant arrived in the UK.

10. The Secretary of State states that the Claimant was listed as an absconder on 8 September 2000. There is a dispute between the parties about when the Claimant was required to report and whether he did report at any stage but this cannot be resolved on the material available.

11. On 20 October 2000, the Claimant's UK asylum claim was refused and certified on safe third country grounds. That decision was served on the Claimant at an interview at the Secretary of State's offices on 20 October 2000.

12. On 21 December 2004, a notice of the Claimant's asylum appeal hearing listed for 14 January 2005 was sent to Kidd Rapinet Solicitors. On 13 January 2005, the solicitors wrote to the Secretary of State informing them that they are no longer in contact with the Claimant and that he may therefore be unaware of the hearing. On 17 January 2005, the Claimant's appeal was dismissed in his absence.

13. On 30 March 2006, the Claimant was convicted of common assault at Marylebone Magistrates Court and fined £75.

14. On 14 September 2006, there is a referral from the Claimant's GP to a plastic surgeon at Chelsea and Westminster hospital. The referral concerned treatment for scars on the Claimant's head which he reported came from a fight in 2005 during which he was hit with a pistol and shot on the right side of the head (without penetrating the brain).

15. The Claimant came to the attention of the UKBA on 25 February 2007 when he was arrested for drink driving and possession of cocaine. On 26 February 2007, the Claimant was bailed to appear on 12 June 2007.

16. On 12 March 2007, the Claimant was issued with an IS96, notification of Temporary Admission, requiring him to report to the Secretary of State's offices on 22 March 2007 and weekly thereafter. The Claimant complied with the reporting requirement until 24 May 2007 when he ceased reporting.

17. On 25 May 2007, the Claimant was convicted at Southwark Crown Court on 3 counts of handling stolen goods and was given a 2-year suspended sentence and required to do 240 hours of community work.

18. On 9 June 2007 the Claimant was listed as an absconder having failed to report on 3 consecutive occasions.

19. Between 01 October 2007 and 31 January 2008 the Claimant committed 'fraud by false representation' offences for which he was later convicted. These are the offences that gave rise to deportation action.

20. On 30 October 2007, a visit to the Claimant's last known address indicated that he was not residing there.

21. On 28 February 2008, the Claimant was convicted at Southwark Crown Court for breach of a suspended sentence resulting from an original conviction on 25 May 2007 to live at the required address.

22. On 29 February 2008, the Claimant was convicted at Horseferry Road Magistrates Court for driving a motor vehicle with excess alcohol and fined £400 and disqualified from driving for 18 months. On the same day he was convicted also of common assault and sentenced to 6 weeks in custody.

23. On 21 April 2008 the Claimant was referred to a psychologist in primary care (in the name of GK) on the basis of having split up with his girlfriend who had cut off connection to her family with him and shut down his office. It is recorded that he has no known previous psychiatric history and was not on any medication and is a 'difficult historian'.

24. On 16 November 2008, the Claimant presented to A & E with depression and suicidal ideation. He was recorded with the name of DK as living at an address in Chelsea and so was referred to the "CRT South Kensington and Chelsea for admission" ("Crisis Resolution Team").

25. On 1 December 2008, the Central & North West London Mental Health NHS Trust CRT Case Summary by Dr Ansari confirmed that the Claimant reported that he was a property developer who is being harassed by his ex-girlfriend's father who has contacts with the

police. He said that his time was being wasted fighting court cases in which he was innocent. Also, he said he had considered suicide by jumping of a bridge but had backed out at last moment. The Claimant reported hearing his dead father's voice over the previous 6 months, but the voice never told him to hurt himself or others but gave advice from his father. The issues were recorded as being largely resolved by the time of his discharge from the crisis team. It is recorded that no medication anti-depressant was needed as he was only mildly depressed and that Olanzapine was discussed but the Claimant was not keen because the 'voices are gone'. The specialist team advised the doctor that if the voices reappeared and worsen significantly 'consider Olanzapine 5 mg'. The Claimant was discharged to care of his GP.

26. On 12 December 2008, the Claimant was referred to a primary care psychologist by his GP. The Claimant's GP states that the CRT thought he had mild depression but the GP believed there was a psychotic element. The Claimant was prescribed Olanzapine (it is not recorded that this was in response to the Claimant hearing voices).

27. On 5 May 2009, Central and North West London NHS Trust wrote to the Claimant's GP confirming that the Claimant was accepted as under the Mental Health team in Chelsea and stating that the consultant, Dr Moodley, was keen for the Claimant to engage with counselling services in primary care.

28. On 10 August 2009 the Claimant's GP wrote a letter to 'Kayders Solicitors' saying that it became apparent since early 2008 that the Claimant was having psychiatric problems. The Claimant's GP says that his "paranoia appears to have increased" and that the Claimant believes that his ex-girlfriend's family were preventing him from conducting his property business and that "an Arab boy" tried to stab him.

29. The Claimant came to the attention of UKBA again on 2 October 2009 when he was arrested by the Metropolitan Police for harassment and fraud. He had in his possession ID items in a variety of names.

30. On 16 October 2009, the Claimant was referred by his GP to Dr Klemperer, Consultant Psychiatrist. The referral states that neither the psychologist nor the GP believe that the Claimant has a primary care diagnosis, that he is having paranoid beliefs and that the Claimant says he is buying both the Cadogan Hotel and Blake's Hotel and has made friends with some of the Royal Family and has recently been dating "a top model". It is recorded that he is 'otherwise well'. The GP confirms that he is taking citalopram and Olanzapine. It is not clear whether the Claimant attended appointments with the psychiatrist on 9 October 2009 and 30 November 2009.

31. On 3 November 2009, the Claimant was convicted of harassment at South Western Magistrates Court, given a sentence of 1 day in custody and placed under a restraining order. Also, on 3 November 2009 it is confirmed that it is now impossible to return the Claimant to Germany, where he first claimed asylum under the relevant EU arrangements because of the delay (due to the Claimant being out of contact with the UKBA). In those circumstances, the Claimant was given temporary admission and released on reporting conditions on 5 November 2009. The Claimant did not report as required but indicated that he would provide medical evidence. After receipt of GP's notes indicating that he was signed off work due to depression the reporting requirement was suspended. His asylum claim now fell to be considered in the UK as he had been here too long for him to be returned to Germany.

32. On 28 November 2009 UKBA received a letter from the Claimant's GP stating that he is being treated for psychiatric problems.

33. On 16 December 2009, the Claimant was last seen by his GP prior to commencing a criminal custodial sentence. He was prescribed citalopram 20mg and was last prescribed a two month supply of Olanzapine in November 2009. On 16 December 2009, he was given a certificate signing him off from work with depression for 3 months backdated from 30 October 2009.

34. On 8 January 2010 and 10 February 2010, the UKBA received medical certificates dated 30 October 2009 and 01 January 2010 signing the Claimant off again for three and two months respectively with depression.

35. On 11 March 2010, the Claimant was convicted on two counts of dishonestly making false representations to make gain for himself or to cause another loss. The Claimant was remanded in custody to HMP Bullwood Hall following conviction.

36. On 11 March 2010, on arrival in HMP Bullwood Hall, the medical records note that the Claimant said that he had 'depression' and was taking citalopram and Olanzapine. He indicated that he had no thoughts of deliberate self harm and on examination his mental health was stable. He was re-prescribed citalopram (10 mg) and Olanzapine (5 mg).

37. On 12 March 2010, the medical reports at HMP Bullwood Hall record the reception health screening which notes that his GP records had been received from the previous responsible primary care clinicians (the Good Practice GP group). It records the medication he was receiving and states that no medical/psychiatric report was required. The notes record that the Claimant stated that he had not received treatment from a psychiatrist outside prison. The assessment of prisoner behaviour and mental state is recorded as 'stable, calm and appropriate'.

38. On 15 April 2010, the Claimant was seen by Dr. Holtmanspoetter, who contacted his GP in community regarding his history of depression and psychotic symptoms. The notes say complaining of lower abdominal pain. The notes record in relation to mental health 'NAD, no psychotic features' and 'history: treated for depression and psychotic disorder. Has seen psychiatrists at C&W H' and notes a complaint of weight gain. The notes record a referral to the GP.

39. On 16 March 2010, the Claimant was sentenced to 2 terms of imprisonment of 18 months to be served consecutively for the false representation offences. In sentencing the Judge took account of the adverse effect of the offence on the elderly female victim from whom the Claimant had taken the money. The Judge stated: *"You also preyed upon her by opening up some form of friendship with her and I take into account, as does the writer of the pre-sentence report, the emotional upset that this will have caused her when she found out that she had been so mistaken in you. Finally you have no credit for any guilty please because you went to trial on both these matters, the effect of which was that she was made to testify….I form the view you may very well have calculated that she would be unwilling to call the police and call attention to herself because of the loss of face involved. That is my impression of you having seen you in the course of the trial, but there is no documentary or other evidence in support of my impression so I have to bear that in mind"*

40. On 14 May 2010, the medical records indicate the Claimant's presentation on the mental health assessment as 'appears mentally stable'. His medication is noted, that he self-administers the medication and that no action is required. The emotional state observations are 'calm and cooperative'. It is noted that no medical reports were required.

41. On 25 May 2010, the Claimant was referred to "mental health in-reach" by the prison medical team 'for further investigation and ongoing treatment' due to 'ideas that may be indicative of an ongoing psychotic illness'.

42. On 5 June 2010, the Claimant completed a response to deportation questionnaire. He said he has a "few businesses", "several properties on my name" and "I have couple 5 star hotel in the United Kingdom."

43. On 7 June 2010, the Claimant had a mental health assessment at HMP Bullwood Hall by Rebecca Hankins, in-reach co-ordinator. The medical notes record that the Claimant reported that he feels well and thinks his mood is fine. He recounts the history of splitting up with his ex-partner and suffering depression as a result for the last 2 years. He notes the episode when he considered jumping off a bridge but was talked out of it by a passer by. He denied any current thoughts of suicide. The Claimant reported good supportive relationships in the community and regular contact with his family. The notes record: *"[H]e appeared to be in stable mood on assessment with no evidence of response to psychotic phenomena. He stated that he heard the voice of his father up until 6 or 7 months ago; he stated that this was a pleasant voice and would advise him to stay out of trouble. He denied hearing voices or any other hallucinatory experience, he denied any thought insertion or ideas of reference….there is no evidence for any further intervention from In-Reach and his case will now be closed."*. The more detailed Mental Health Assessment form records similar information but notes under 'mental health history' that he was treated by his GP for depression and 'No intervention from secondary mental health services'. His mood is recorded as 'stable, no evidence of low mood (the Claimant reports a good mood with no problems). No current risks to himself or others are identified. The conclusion is *"[D] was appropriate throughout the assessment…there was no evidence of response to psychotic phenomena, nor was there evidence of thought disorder, insertion, ideas of reference or bizarre belief. His emotions and behaviour were congruent to the situation and no concerns were raised... no evidence for any further input from In-Reach; for closure"*. The Claimant was advised to remain on his medication, including anti-psychotics (citalopram and Olanzapine) and to see his GP upon release in 6 weeks (no decision having been taken at that time that the Claimant would be detained under immigration powers).

44. On 4 August 2010, the Claimant had his asylum screening interview. He repeated the claim that he was in Turkey in 2000. The Claimant reported that he has taken anti-depressants since 2008. He claimed to have no convictions in the UK other than the current conviction. He claimed to be a PKK supporter but was not involved in any terrorist acts. Also he claimed that UK police arrested him and he was "taken to Notting Hill Police State for interview which was given by the Turkish Government to Scotland Yard who is supporting the PKK" and that he was in the Turkish newspaper and on Turkish TV.

45. On 12 August 2010, the Claimant was notified of his liability to deportation under the Automatic Deportation regime and given the one stop warning that he was required to state all information relevant to whether he falls within any of the exceptions to automatic

deportation (and provided with a detailed questionnaire to assist with providing relevant information).

46. On 23 August 2010 the Claimant had his asylum interview. In his interview he said he was a PKK supporter whose family had provided financial support to the PKK so he had been arrested 3 times by the Turkish authorities in 1999 and 2000 but was not charged. He described his family's longstanding hotel businesses. He stated that he and his family had business interests in the UK: properties, companies, and hotels. The Claimant also said that he was arrested in the UK for funding terrorism and money laundering. He said he took medication for depression that started in 2008 (2 tablets a day).

47. On 25 September 2010 the Claimant said he no longer wishes to take citalopram or Olanzapine and his prescriptions were stopped.

48. On 2 September 2010, the Claimant's restraining order was revoked by South Western Magistrates' Court.

49. On 22 November 2010, the Secretary of State's GCID Case Record Sheet records the Secretary of State's caseworker's internal consideration of the Claimant's asylum claim. The consideration says that the Claimant's claims relating to arrests and businesses were considered to be elaborate, were investigated and shown to be false. It refers to the letter dated 10 August 2009 from the Claimant's GP (to Kayders Solicitors, see above), notes that the Claimant has been suffering from paranoia and was prescribed anti-psychotic medication in the past, and considers that his claims relating to his business transactions might be linked to his mental health. However, the same note later states "there is nothing to indicate that [the Claimant] is not well at present".

50. As well as consideration of the asylum claim it was necessary for the Claimant's case to be considered by the Criminal Casework Directorate (CCD). As a Foreign National Offender (FNO), the Claimant fell within the Automatic Deportation regime under s.32 UK Borders Act 2007 in principle. Therefore, consideration was required by the CCD as to whether he fell within any of the exceptions to the statutory regime (which includes establishing a right to international protection under the Refugee Convention or the ECHR).

51. On 29 November 2010 the Criminal Casework Directorate responsible officer ('the CCD caseworker') made the decision to detain the Claimant pursuant to s. 36(1) of the Borders Act 2007 pending consideration of whether any of the exceptions to the Automatic Deportation regime applied. The decision records similar information to the asylum consideration in relation to the Claimant's mental health. In her statement the CCD caseworker states that she had a letter of 10 August 2009 by the Claimant's GP and that she considered Chapter 55.10 EIG but that "on the materials available to me there is there was no evidence upon which I could have concluded that the Claimant was currently suffering from a serious mental illness that could not be managed satisfactorily in detention." The minute of the decision to detain records there is 'no evidence' of any 'compassionate factors'.

52. On 30 November 2010, the Minute of the decision to detain under s 36(1) Border Act 2007 was completed. It concludes that the Claimant is not suitable for release in the absence of evidence of family members in the UK given the risk of absconding again and re-offending. The proposal to detain was agreed by the CCD Team Leader**.** On that day

an IS.91RA (risk assessment) form was faxed to prison and the prison was asked to comment on all questions.

53. On 6 December 2010, the Claimant asked the prison staff to re-start his medication because he was feeling anxious and depressed. He was given citalopram but not Olanzapine.

54. On 7 December 2010, HMP Bullwood Hall sent back the IS.91RA risk assessment form. The form was returned with a tick in the box marked "psychiatric disorder" under the potential risk factor categories, which appear under the statement: "*Any positive indicators of risk MUST be explained fully in writing below. Indication of risk should take into account any significant historical information as well as current circumstances and behaviour as appropriate"*. The only comment is "*1 x harassment sentence – revoked*". This is received by UKBA on the same day.

55. On 9 December 2010, the IS 91 Detention Authority was completed by UKBA. No box is checked for 'psychiatric illness' requiring any special monitoring or supervision and nothing is recorded in the section for medication.

'First period' of detention

56. The Claimant entered immigration detention on 9 December 2010 and was detained at HMP Bullwood Hall until his transfer on 21 December 2010 to an IRC.

57. The Claimant's latest asylum claim was refused on 14 December 2010.

58. On 18 December 2010, the Claimant's medical records were transferred from prison to the IRC primary care team.

59. On 21 December 2010, the Claimant was transferred from HMP Bullwood Hall to IRC Harmondsworth.

60. During his health care induction the Claimant informs A. Staples (a mental health nurse) that he has been under the care of a psychiatrist. The induction form records that the Claimant reported suffering from depression since 2008 for which he takes citalopram and that he was taking Olanzapine until approximately 3 months ago but stopped Olanzapine due to weight gain. It records the incident of the Claimant considering throwing himself in the River Thames in 2008 but records there is no current suicidal ideation. A negative response is recorded against the question on the form assessing whether the Detainee seemed anxious, withdrawn or depressed and whether any concerns had been raised by outside agencies. The Claimant is recorded as stating that he was coping well until he learnt that he would be detained and that he asked to see a psychiatrist. The Claimant's medical notes say "refer to GP and would like to see psychiatrist'. There is a dispute between the parties as to whether a healthcare assessment was conducted for the purposes of Rule 34 of the Detention Centre Rules, which the Court is asked to resolve.

61. On 31 December 2010, the Claimant saw a GP and was prescribed Omeprazole for gastritis.

62. On 5 January 2011, the Claimant's detention was reviewed and continued detention authorised.

63. On 25 January 2011, the Secretary of State made a decision to deport and a deportation order was signed against the Claimant.

64. On 1 February 2011, the Claimant was briefly transferred to Colnbrook IRC for service of documents. A healthcare induction was conducted at Colnbrook IRC followed by a GP appointment. The Claimant signed a routine disclaimer allowing the Colnbrook healthcare team to disclose relevant information regarding his medical conditions, history or mental heath to named entities including the UKBA 'whilst in the establishment' *i.e.* Colnbrook IRC. He was returned to Harmondsworth IRC the same day on 21 February 2011.

65. On 2 February 2011, the Claimant's detention was reviewed and maintained.

66. On 8 February 2011, the Claimant did not attend an appointment with the GP.

67. On 17 February 2011, an Emergency Travel Document interview was conducted to arrange travel documents for the Claimant.

68. On 23 February 2011, the medical notes record that the Claimant did not attend an appointment with the GP.

69. On 28 February and 28 March 2011, the Claimant's detention was reviewed and his continued detention authorised.

70. On 10 April 2011, the Claimant requested temporary admission on the basis that he did not regard himself a properly liable to detention. On 12 April 2011, the Claimant wrote a letter to the Secretary of State's caseworker asking why it had taken so long to serve the deportation order and saying: *"... As far as I concern you're part of the corruption which related with Nothing hill gate police officers and Drug dealer Simon Ford and Radwan Alrawi That's why they keep chasing my immigration case to know what's going on. I have been visited by two Scotlandyard officers. They know the case was set up. They know you're link wit them. That's why you're holding me here to not release any evidence to media or public. Deport me now where you can deport me. Mr. 'J' ??? Ford."* [sic]

71. On 14 April 2011, the Claimant was briefly transferred to Colnbrook IRC for one day where he saw a nurse and then later a GP. The medical notes record that the Claimant was on citalopram for depression and considered his mental health was currently stable but was feeling stressed. He denied suicidal thoughts and self harm to the nurse.

72. On 18 April 2011, the Claimant lodged an appeal against the refusal of his asylum claim.

73. On 19 April 2011, a completed application for Emergency Travel Documents from the Turkish Embassy was submitted.

74. On 28 April 2011, the Claimant's Harmondsworth IRC medical notes record 'would like to restart [Olanzapine] as hearing voices'. Olanzapine 5 mg was prescribed for 28 days. There is a dispute as to whether Olanzapine was re-prescribed after the expiry of the 28 day period before 21 July 2011 and whether that dispute can be resolved on the information available.

75. Also, on 28 April 2011, the Claimant's detention was reviewed and his continued detention authorised.

76. On 4 May 2011, the Claimant was seen by a GP, Dr. Walker, who records that the Claimant has 'long-standing mental health issues' and that the Claimant feels that he is being bullied, reported this to officers but they told him to 'keep head down'. The note also records that the Claimant is 'feeling stressed' and that his court case is on 7/5/11.

77. On 5 May 2011, the Secretary of State's CCD caseworker was advised that she should not pursue Emergency Travel Documentation until the Claimant's appeal rights were exhausted for his asylum claim.

78. On 6 May 2011, the Claimant's previous legal representatives ceased to represent him. The solicitors wrote to him saying this was because he claimed to have £8m in savings and to be a funder of the PKK.

79. On 7 May 2011, the Claimant wrote to his CCD caseworker requesting information about the position of his case. The caseworker replies on 8 May 2011 confirming that he has a First Tier Tribunal hearing of his appeal scheduled for 17 May 2011.

80. On 10 May 2011 the medical notes record the Claimant complained of bullying and that he was told to approach UKBA as this is not a medical problem.

81. On 11 May 2011, the Claimant wrote to his caseworker questioning the history recorded in the Monthly Progress report.

82. On 14 May 2011, the Claimant's medical notes record that the Claimant did not attend an appointment with the GP.

83. On 17 May 2011, the Claimant has his FTT asylum appeal hearing. The Claimant withdrew the bail application that was listed for that day. The Claimant applied to adjourn the appeal and that was refused. During the hearing the Immigration Judge raised concerns about the Claimant's mental health which were passed on to UKBA.

84. On 18 May 2011, the Claimant's detention was reviewed and his continued detention authorised.

'Second period' of detention

85. On 19 May 2011, the GCID Case Record entry notes concerns around mental health following hearing on 17/5/11 stating that the Claimant "was making some extravagant claims, his behaviour was such that the Judge believed him to be delusional". The CCD Caseworker spoke with officers at Harmondsworth to check if there were any records of the subject having suffered any mental health problems, and noted "informed that from the subjects casefile, he is not believed to be suffering from any mental health conditions." and 'Request made for the subject to be assessed by a mental health official'.

86. On 19 May 2011 a fax was sent from UKBA to Harmondsworth IRC requesting a mental health assessment because the Claimant's behaviour and actions at court were "a cause for concern for the Judge and other court members" and the Judge believed the Claimant "to be delusional if he genuinely believed his claims and statements."

87. On 19 May 2011, the Claimant instructed his current representatives, Wilson Solicitors LLP.

88. On 20 May 2011, the Health Care Manager at Harmondsworth wrote a fax to UKBA saying that the Claimant has been seen by the GP who has not asked for a mental health assessment at this time, it is recorded that the Claimant is stable on medication, and the only concern relates to allegations of bullying. There is a dispute between the parties as to whether this fax is accurate.

89. On 24 May 2011, the Claimant's medical notes record that he did not attend an appointment with the GP.

90. On 25 May 2011, the Claimant's detention was reviewed and his continued detention authorised. The review refers to the Claimant's behaviour at his appeal hearing giving cause for concern, 'However, healthcare have confirmed that there is no evidence on the file to support this and the Doctor does not consider a mental health assessment appropriate. It is considered likely Mr. K put on this behaviour in an attempt to sway the appeal judge'. It is recorded that release has been considered in accordance with Chapter 55 EIG but refused in the light of the risk of reoffending and absconding.

91. On 1 June 2011, the Claimant's asylum appeal was dismissed by the First-tier Tribunal (IAC). The determination includes the following: "The appellant's evidence had a bizarre quality, which seemed to increase in absurdity towards the end of his evidence." In relation to the Article 8 ECHR claim the FTT stated "We note that he has received treatment for depression in 2009 and 2010 as evidence by prescriptions from his General Practitioner…. We are not aware of any medical treatment he has received whilst in detention. There is insufficient evidence before us that the appellant is suffering from any major health problems of either a physical or mental nature" and conclude he can be removed. The Claimant's claims regarding his businesses, his arrests for terrorism offences, and being shot in 2005 by Turkish agents were rejected.

92. On 8 June 2011, the Claimant's representatives provide an authority to act declaration to the UKBA.

93. On 10 June 2011, the Claimant lodged an appeal against the refusal of his asylum appeal.

94. On the same day, the Claimant's representatives wrote to Harmondsworth medical team requesting details of his current medication.

95. On 13 June 2011, the UKBA chased up the healthcare team at the IRC to provide what information was possible about the Claimant's medical position.

96. Permission to appeal to the Upper Tribunal was refused on 22 June 2011 by the First Tier Tribunal. The Claimant renewed this application to the Upper Tribunal.

97. On 23 June 2011, the Claimant's detention was reviewed and his continued detention authorised 'in accordance with Chapter 55 EIG'. In the detailed facts of the case recorded, there is reference to mental health concerns and that a request was made by the CCD caseworker to the primary care team for a mental health assessment but this was declined as the 'doctor' felt it was not needed.

98. On 27 June 2011, Harmondsworth medical team responded to the Claimant's representatives letter of 10/6/11 stating "*This gentleman is currently taking citraprim 10 mg daily in the morning*".

99. On 30 June 2011, the Claimant's representatives wrote to Harmondsworth Medical Team requesting confirmation of whether the Claimant had been prescribed Olanzapine since being detained and noting that on 28 April 2011 the Claimant requested that he be prescribed Olanzapine because he is hearing voices.

100. On 1 July 2011, Harmondsworth healthcare contract to provide primary healthcare services was transferred from 'Drummonds' to 'Primecare'.

101. On 4 July 2011, a bail hearing was scheduled before the FTT for 7 July 2011.

102. On 7 July 2011, the Claimant attended a GP appointment at which he reported that the citalopram was not helping and that he feels low sometimes and has occasional suicidal thoughts.

103. On 8 July 2011, the Claimant's representatives instructed Dr Ben Robinson, NHS Consultant Psychiatrist at Camden and Islington Mental Health Trust and Medical Justice volunteer doctor, to prepare a medical report. In their instructions the Claimant's representatives provide details of bizarre instructions that they have been unable to substantiate.

104. On 9 July 2011, Dr Ben Robinson assessed the Claimant for 2 hours. Dr Robinson wrote his opinion directly on the Claimant's medical notes. The notes say: "Stress of detention is worsening mental health problems. – Extensive delusional system. – Paranoia about Turkish Government controlling UK policy. – Suicidal thoughts." Following his appointment Dr Robinson wrote a letter setting out his preliminary views. In that letter he said that the Claimant is "currently psychotic and requires anti-psychotic medication which he used to take but is not being given currently in detention. It is unclear why this is so, because when I asked if he would be willing to take such medication he said that he would. [The Claimant] also has retrograde memory loss and shows some signs of alcohol-related neural degeneration which requires further investigation."

105. On 11 July 2011, the Claimant's former GP wrote to the Claimant's representatives confirming that in 2009 he was prescribed citalopram and Olanzapine. His GP notes that she thought he had a psychotic element in addition to the psychiatric crisis team's 2008 diagnosis of mild depression. She says that although he was re-referred to psychiatrists in Autumn 2009 contact was never made.

106. On 12 July 2011, Dr Robinson completed his psychiatric report. His opinion is that the Claimant demonstrates several different types of psychotic thoughts including: Paranoid Persecutory Delusions, Grandiose Delusions related to PKK, relationships, property and crime, and potentially Passivity Phenomena. He says that the Claimant indicated that occasionally he hears the voice of his dead father but this does not seem to represent a hallucination but rather a strong memory. Dr Robinson concludes that, in his opinion, the Claimant is suffering from a psychotic disorder, needs medication, needs psychological support, detention is worsening his illness making his beliefs more fixed, and that in his opinion the Claimant does not appear to have been receiving adequate treatment.

107. On 18 July 2011, the Claimant's representatives wrote to the Harmondsworth Medical Team drawing their attention to the Claimant's poor mental health and requesting confirmation of what steps have been taken to alert the Secretary of State to this and what medical treatment the Claimant has received in detention. The medical team was requested to urgently arrange an appointment with a GP and Consultant Psychiatrist.

108. On 18 July 2011, the Claimant's representatives wrote to UKBA requesting temporary admission and drawing UKBA's attention to the Claimant's poor mental health and Dr Robinson's initial opinion.

109. On 20 July 2011, the Claimant's detention was reviewed and his continued detention authorised. The review refers to mental health concerns, but says an assessment will not be done because the "doctor" felt it was not needed.

110. On 21 July 2011, the Claimant's medical notes record that there is a "medication problem", and the Claimant wants to start again, "Olanzapine 5mg od". On the same day the Claimant's prescription chart records a 28 day supply of Olanzapine is prescribed.

111. On 27 July 2011, the Claimant's representatives wrote to Harmondsworth Healthcare requesting clarification of when the Claimant was prescribed Olanzapine and the reasons for stopping Olanzapine after the April 2011 prescription.

112. On 2 August 2011, the IRC healthcare team seek a medical disclaimer to allow information about the Claimant's health to be given to UKBA. This is provided on 4 August 2011.

113. By a letter dated 4 August 2011 (recorded as received on 5 August 2011) the report of Dr Robinson (dated 12 July 2011) is provided to the Secretary of State with a copy of the letter dated 18 July 2011 in relation to temporary admission. The letter and enclosures are copied to Harmondsworth Healthcare. The GCID notes for 5 August 2011 record the receipt of the letter and report and an attempt to contact the Healthcare Manager at Harmonsdsworth IRC and a request that the healthcare manager contact the CCD caseworker.

114. On 7 August 2011, the Claimant was referred to the NHS Consultant Psychiatrist. He was booked in to see the senior nurse on 9 August 2011.

115. On 11 August 2011, the UKBA caseworker spoke with 'Val' (Valerie Anderson, Healthcare Manager and Senior Nurse at Harmondsworth IRC), who explained that 'unless the guards had cause for concern regarding the subject's mental health a psychiatric report would not have been done'. The caseworker requested that a mental health assessment be carried out. It was confirmed that the Claimant was due to see the psychiatrist on 12 August 2011 and he had seen by the Registered Mental Health Nurse.

116. On 12 August 2011, the medical notes record that the Claimant refused to attend the appointment with the psychiatrist.

117. On 17 August 2011, the GCID notes record that the CCD caseworker sent a message to the Healthcare Manager at Harmondsworth to check if the Claimant was seen by a psychiatrist. The Claimant confirmed that he was not willing to see Turkish officials to progress an ETD.

118. Also on 17 August 2011, the Claimant's detention was reviewed and his continued detention authorised in reliance on the risk of absconding and reoffending. The review refers to receipt of letter from the Claimant's representatives on 5 August 2011 claiming that the Claimant is suffering from a "psychotic disorder", records that he will be seen by the psychiatrist and that once the report is available the matter will be reassessed.

119. On 18 August 2011, the Claimant was seen for a mental health review.

120. On 20 August 2011, the Claimant was seen by Dr. Burrun, NHS Consultant Psychiatrist. The notes from this assessment say: Known to be suffering from 'depression', that the Claimant is feeling better since re-starting Olanzapine, he hears father's voice less frequently, and he denies any psychotic symptoms. The medical plan is to continue citalopram and Olanzapine, individual support and for a further review.

121. On 22 August 2011, the Claimant was refused bail by the First-tier Tribunal.

122. On 26 August 2011, the Claimant's representatives sent a Letter Before Action to the Secretary of State.

123. On 30 August 2011, the Harmondsworth Healthcare Services (Primecare) responded to the Claimant's Representative's letter of 27/7/2011 stating that they are unable to clarify the situation with the Claimant's medication under the previous provider since Primecare had recently taken over responsibility for the provision of healthcare. It is confirmed that the Claimant had been seen by a consultant psychiatrist, Dr Burrun, and been reviewed by the mental health nurse.

124. On 1 September 2011, the Claimant was granted permission to appeal to the Upper Tribunal citing concerns around the refusal of an adjournment application.

125. On 6 September 2011, the Claimant was seen by the healthcare team and reported to be "calm & cheerful" with "no current issues." He was advised of the importance of continuing with his medication to lessen the chance of future relapse.

126. On 9 September 2011, the FTT heard an application for bail relying on mental illness grounds, the opinion of Dr Robinson and several witness statements. The Immigration Judge who refused bail noted that there was a significant risk of absconding 'in light of his psychiatric condition, which is said to involve delusions and he may be suffering from schizophrenia'. The judge also noted that he is said to need regular medication. He concluded that in those circumstances the Claimant could not be released in the absence of a surety. It was said that any concern about continued detention whilst the appeal was outstanding could be addressed by requesting an expedited hearing.

127. On 12 September 2011, the Claimant wrote to his UKBA caseworker requesting evidence that he has previously absconded and saying: "As far I know. As far I concern behind all problems always same people which related with you. you are linked with those people who is well known in london as crooks. Who robbing people legiment uou can't sue them. because they're in government. Some Police officers. some politicians. Some Accountant's Lawyers are in same game. you're ripping people by the law can you imagine I have only problem with Nottinghill gate police station. Even my area doesn't cover this police station but they always there... Just let you know I am taking legal action against you."

128. On 13 September 2011, the CCD Caseworker spoke to the UKBA liaison at Harmondsworth requesting information as to whether the psychiatric appointment went ahead. The liaison officer confirmed that he could not give any medical details but that the appointment went ahead. The CCD caseworker asked for a copy of the medical report and the liaison officer confirmed that a copy of a medical report can be provided only if a medical disclaimer was provided. The CCD caseworker wrote to Harmondsworth healthcare centre noting that a medical disclaimer was needed to permit the UKBA to be given the results of the psychiatric assessment undertaken in August and requested a copy of the psychiatric report of the treating clinician.

129. On 14 September 2011, the Claimant's detention was reviewed and his continued detention authorised. The review refers to the investigations into the Claimant's mental health and says that UKBA was still awaiting outcome of psychiatric assessment.

130. On 14 September 2011, the Claimant signed a disclaimer giving consent to release of his medical records by Harmondsworth healthcare team to UKBA, receipt of which was confirmed by the UKBA caseworker on 15 September 2011.

131. On 15 September 2011, the Secretary of State responded to the Claimant's letter before action. The response notes receipt of Dr Robinson's opinion under cover of letter dated 4 August 2011 and says: "In order for the UK Border Agency to fully consider whether detention is appropriate where a person may be suffering from a mental health condition a psychiatric assessment and report must be completed on behalf of the UK Border Agency. This has now been undertaken." It was said that a medical disclaimer is required for disclosure of the 'report' and the disclaimer was completed by the Claimant on 14 September 2014.

132. On 15 September 2011, the GCID notes record that detention will be reviewed once the psychiatric report is received from Harmondsworth. On the same day the Claimant's representatives wrote to Harmondsworth healthcare again requesting clarification of the Claimant's medication and asking for disclosure of the records relating to the Consultant Psychiatrist's visit and review by the mental health nurse.

133. On 20 September 2011, the ETD application was refused by the Turkish Embassy as the details provided by the Claimant were not verifiable as correct.

134. On 22 September 2011, the present judicial review proceedings were filed.

135. On 23 September 2011 the Claimant was seen in Healthcare and the notes record that the Claimant was complaining of hearing his father's voice telling him to 'do things' and keeping him awake at night. The Claimant's Olanzapine was increased to 10 mg.

136. On 26 September 2011, the Claimant's representatives wrote to the Secretary of State's CCD caseworker enclosing all medical evidence submitted in support of the judicial review and asking that the caseworker ensure it is provided to the Consultant Psychiatrist assessing the Claimant to consider when forming his diagnosis. The letter records that a request had now been made to Hillingdon Social Services for a s.47 assessment of the Claimant (in relation to provision of care on any release).

137. On 29 September 2011, the Claimant's representatives again wrote to the CCD caseworker asking for confirmation that the Claimant's medical papers were provided to the psychiatrist assessing Claimant and requesting a copy of the psychiatrist's report.

138. On 30 September 2011, the UKBA caseworker contacted the healthcare team again to seek a response to the request of a copy of the psychiatric report of the treating Consultant. The caseworker was told that she will be given a copy as soon as possible.

139. On 5 October 2011, the Claimant was assessed for 2 hours by Dr Amlan Basu, independent Consultant Forensic Psychiatrist instructed by the Claimant's solicitors

140. On 7 October 2011, the CCD caseworker made a request to Harmondsworth for the Claimant's Healthcare records.

141. On 11 October 2011, the Claimant's representatives wrote to the Treasury Solicitor asking for confirmation of whether the psychiatrist at Harmondsworth had access to the Claimant's medical records and Dr Ben Robinson's report when assessing the Claimant's mental health.

142. Also on 11 October 2011, the Claimant was seen by a GP after complaining of heartburn.

143. On the same date, the Claimant's detention was reviewed and his continued detention authorised. The review refers to mental health concerns and the steps taken to investigate the Claimant's mental health. It states that the detention and healthcare records have been requested from the IRC, the outcome of an assessment is awaited and that the case must be reassessed once the outcome on the Claimant's psychiatric condition is received.

144. On 13 October 2011, a bail application was received scheduled for 18 October 2011. This application was withdrawn and scheduled for 20 October 2011.

145. On 18 October 2011, the UKBA received the Claimant's medical notes pursuant to the medical disclaimer signed.

146. On 19 October 2011 Dr Basu completed his first report on the Claimant

147. On 21 October 2011, the Claimant was released on bail by the FTT having now provided a surety and Dr Basu's report.

Post release

148. The following facts are not considered by the Secretary of State to be relevant to the question of the lawfulness of the Claimant's detention since they post-date the Claimant's release from detention. However, in my view, they form part of the relevant factual background.

149. On 28 October 2011 the Claimant starts reporting to the Secretary of State's offices and reports regularly thereafter.

150. On 28 November 2011 there is a review (post-release) of mental health status by Haringey Primary Care Trust Mental Health Team nurse. The plan is to continue with

current medication 10 mg at night and 'care to be transferred to the Psychosis Complex care team for longer term monitoring and support'.

151. On 22 December 2011 Upper Tribunal finds that the First-tier Tribunal erred in law by failing to adjourn, the determination dismissing Claimant's asylum and deportation appeal is set aside and the case is remitted back to the First-tier Tribunal.

152. On 25 June 2012 the Claimant's asylum and deportation appeal is allowed on refugee and human rights grounds (Article 3). The Tribunal accepts the reports and diagnosis (schizophrenia) of Dr Basu and Dr Robinson and finds that the Claimant suffers from delusions and cannot be believed with regard to his claimed business dealings and relationships. The Secretary of State did not appeal this decision and did not dispute the medical evidence at that hearing.

153. On 14 September 2012 the Claimant was granted refugee status.

154. On 16 April 2013 the Claimant was examined for 2 hours for a second time by Dr Basu. On 26 June 2013 Dr Basu completed his second report on the Claimant.

155. On 14 March 2014, approximately two years and seven months after he assessed the Claimant, Dr Burrun provided a witness statement for the purposes of these proceedings.

THE LAW

Immigration detention of the mentally ill

156. Administrative detention under s.36(1) or (2) Borders Act 2007 will be unlawful on public law grounds if the Secretary of State fails properly, *i.e.* lawfully, to apply her policy in Chapter 55.10 of the Enforcement Instructions and Guidance ('EIG').

157. Chapter 55.10 of the Secretary of State's Enforcement Instructions and Guidance provides as follows:

> "**55.10. Persons considered unsuitable for detention**
>
> 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.
>
> In criminal casework cases, the risk of further offending or harm to the public must be carefully weighed against the reason why the individual may be unsuitable for detention. There may be cases where the risk of harm to the public is such that it outweighs factors that would otherwise normally indicate that a person was unsuitable for detention.
>
> The following are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration detention accommodation or prisons:

- Unaccompanied children and young persons under the age of 18 (see 55.9.3 above).

- The elderly, especially where significant or constant supervision is required which cannot be satisfactorily managed within detention.

- Pregnant women, unless there is the clear prospect of early removal and medical advice suggests no question of confinement prior to this (but see 55.4 above for the detention of women in the early stages of pregnancy at Yarl's Wood).

- Those suffering from serious medical conditions which cannot be satisfactorily managed within detention.

- Those suffering from serious mental illness which cannot be satisfactorily managed within detention (in criminal casework cases, please contact the specialist mentally disordered offender team). 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 Mental Health Act.

- Those where there is independent evidence that they have been tortured.

- People with serious disabilities which cannot be satisfactorily managed within detention.

- Persons identified by the competent authorities as victims of trafficking (as set out in Chapter 9, which contains very specific criteria concerning detention of such persons).

If a decision is made to detain a person in any of the above categories, the caseworker must set out the very exceptional circumstances for doing so on file."

158. The phrase "*…suffering serious mental illness which cannot be satisfactorily managed within detention"* has been the subject of recent and definitive guidance by the Court of Appeal in *R (Das) v SSHD* [2014] EWCA Civ 45. I set out below Ms Anderson's summary of the guidance in *Das* adopted by Mr CMG Ockelton, Vice President of the Upper Tribunal (sitting as a Deputy High Court Judge) in *SA(Holland) v. SSHD* [2014] EWHC 2570 (Admin) which is a useful summary of the general principles:

(1) When interpreting and applying Chapter 55.10 it was essential to keep firmly in mind the purpose of the policy, which was to ensure compliance with the requirements of immigration control (especially in the context of the removal of FNOs where that was

accorded a particular importance by the statutory policy of Parliament reflected in the automatic deportation regime and that of the Secretary of State) but prevent treatment that was inhumane [46].

(2) A purposive and pragmatic construction was required "[i]n the light of the purpose of immigration detention identified above, that is enabling lawful removal pursuant to an effective immigration policy, the policy seeks to ensure that account is taken of the health of the individuals affected and (save in very exceptional circumstances) to prevent the detention of those who, because of a serious mental illness are not fit to be detained because their illness cannot be satisfactorily managed in detention" [47].

(3) The phrase "suffering from a serious mental illness which cannot be managed satisfactorily within detention" must not be dissected but considered as a whole. [47] and [57].

(4) The policy exception in Chapter 55.10 does not apply simply because a person has a diagnosis of a mental illness that is regarded as 'serious' [48], [50], [55] and [57]. In LE (Jamaica) the claimant had a long established condition of Paranoid Schizophrenia (which had rendered him unfit to plead to criminal charges) but the policy was not engaged as the condition was one that could be managed satisfactorily in detention.

(5) The 'threshold for applicability of the policy' is that the mental illness is serious enough to mean it cannot be managed satisfactorily in detention. [67]

(6) 'Satisfactory management' involves considerations such as the medication required and whether 'demonstrated needs' can or cannot be provided by the place of detention. The Court noted that OM (Nigeria) at [33] shows that some of those suffering significant adverse effects of mental illness may be managed appropriately in detention, the views of the experts were divided but the Court of Appeal found that the balance of expert advice was that her illness could be managed appropriately in detention [67]. It is noted that in OM there were expert reports in much stronger terms than in this case that stated that the treatment needed by OM was not available in detention and that her mental health was deteriorating significantly as a result of detention so she was unfit to be detained (and lacked capacity to act). Whilst the responsible clinicians did not provide 'expert reports' in the same way as those procured by claimant representatives, the Court considered the views expressed in the medical papers to the effect that the needs for satisfactory management of OM's mental health were met in detention and the Court of Appeal accepted the approach of the responsible clinicians.

(7) The Secretary of State was generally entitled to rely on the responsible clinicians where reasonable enquiries had been made and the requirements of Chapter 55.10 were considered where applicable, so long as there was not a total abdication of the Secretary of State's own responsibilities to the clinicians. [70].

(8) For the purposes of the decision in Das, the Court did not decide whether 'satisfactory management' involved facilitating the possibility of recovery but at [71] the Court 'strongly doubted' that this was the correct approach as:

- this was unlikely to be the intention of the policy given its purpose
- it was unlikely to be the natural construction of the words used
- it was inconsistent with the established jurisprudence of the higher courts
- it was impractical given the variance of treatment available in the community
- it was inconsistent with the context of the purpose of removal from the UK as soon as possible

(9) Where the threshold for applicability was met and a serious mental illness could not be managed satisfactorily in detention so the policy applied – the 'very exceptional circumstances' test was a demanding one. It was not met by the mere fact of liability for circumstances' test was a demanding one. It was not met by the mere fact of liability for removal and the refusal to repatriate voluntarily. It could be met by circumstances such as the detainee posing a serious risk of harm to the public or the anticipated period of further detention being short. It required an assessment of where on the 'spectrum' of seriousness the case fell (that spectrum including those with no record of offending right through to the most serious terrorism cases). [68]."

159. The Secretary of State's exercise of the power to detain under Chapter 55.10 is reviewable on public law grounds (*R (EO) v SSHD* [2013] EWHC 1236 (Admin), [16]), including classic *Tameside* grounds (*Secretary of State for Education v Tameside MBC* [1977] AC 1014, 1065).

160. The issues commonly arising are threefold: (i) first, whether the detainee was suffering a "*serious mental illness which could not properly be managed in detention*"; (ii) second, if so, whether or not there existed "*very exceptional circumstances*" justifying detention in any event; and (iii) third, even if the Secretary of State failed to act in accordance with her policy, whether the Secretary of State would have detained in any event, if proper

regard had been had to the policy, so that any damages to be awarded should be nominal, applying the guidance in *R(Lumba) v. SSHD* [2011] UKSC 12.

ANALYSIS

LEGAL ISSUES

161. I turn first to a number of specific legal issues raised by Counsel in the course of argument.

Evidence or assumptions?

162. The first legal issue related to the approach by the court to the making of findings of fact. The Claimant invited the Court to reach 'the same general findings' as to the conditions of detention and the quality of the healthcare provision at Harmondsworth IRC as those of Laing QC in *R (BA) v SSHD* [2011] EWHC 2748 (Admin) (A/13/361) HHJ Anthony Thornton QC in *S v SSHD* [2014] EWHC 50 (Admin) (A/30/1125).

163. Ms Anderson, on behalf of the Secretary of State, took exception to this approach on the basis of relevance. In my view, she was right do so. The practice of claimants selecting particular decisions with favourable outcomes and asking the Court to be influenced by them has been deplored by the Courts, see *e.g.* Irwin J in *NAB* [2010] EWHC 3137 at [77]-[80]. In *Das* [2014] EWCA Civ 45, the Court of Appeal refused to make assumptions about inadequate provision of mental health care in IRCs at the invitation of intervenors (Medical Justice). I reject the Claimant's approach. Cases should be decided on evidence, not assumptions.

The Tameside issue

164. The second (and major) legal issue between the parties related to the question of the nature of the *Tameside* duty in the context of Chapter 55.10 EIG and the decision of Sales J and the Court of Appeal in *R (Das) v SSHD* [2013] EWHC 683 (Admin) and [2014] EWCA Civ 45.

Submissions

165. The Claimant's submissions can be summarised as follows:

(1) First, a *Tameside* duty to inquire was triggered whenever "there was a real (as opposed to a fanciful or insubstantial) possibility that an immigrant facing removal was suffering from serious mental ill-health which could not be satisfactorily managed while in detention" (*per* Sales J in *R (Das) v. SSHD* (*supra*) at [42]).

(2) Second, Sales J laid down a general test in *Das* for the application of *Tameside* in this context which still held good and which was supported by passages in the Court of Appeal in *R (Das) v. SSHD* (*supra)* [70], in *R(S) v. SSHD* [2011] EWHC 2120 (Admin) [171], and in *R(S) v. SSHD* [2011] EWHC 2748 (Admin) [183-186].

(3) Third, there was a continuing *Tameside* duty which arose at every monthly review required by Chapter 55.8 EIG.

(4) Fourth, the threshold at which the *Tameside* duty was engaged was lower than the threshold at which the policy at Chapter 55.10 EIG applied to the individual.

(5) Fifth, once there was a 'real possibility' that an individual fell within the policy, no reasonable decision-maker could apply the policy without obtaining 'up-to-date psychiatric evidence'.

(6) Sixth, at all material times the Secretary of State failed to make sufficient inquiries in the present case at to the Claimant's condition.

166. Ms Anderson's submissions on behalf of the Secretary of State can be summarised as follows:

(1) First, no general legal test was developed by Sales J in *Das* in the context of Chapter 55.10 EIG, nor is any appropriate.

(2) Second, even if Sales J purported to formulate a general test, any such test did not survive the Court of Appeal which set his decision aside.

(3) Third, in any event, on the facts of the *Das* case, an orthodox application of *Tameside* plainly required the Secretary of State there to consider a psychiatric report raising mental heath issues since one was in the actual possession of the UKBA at the time of the detention decision.

(4) Fourth, there was no *Tameside* or other public law breach in this case.

Classic Tameside principles

167. The general principles arising out of the *Tameside* duty were summarised in *R (Plantagenet Alliance Limited) v. Secretary of State for Justice* [2014] EWHC 1662 (Admin) [99]-[100] as follows:

> "99. A public body has a duty to carry out a sufficient inquiry prior to making its decision. This is sometimes known as the 'Tameside' duty since the principle derives from Lord Diplock's speech in *Secretary of State for Education and Science v Tameside MBC* [1977] AC 1014, where he said (at page 1065B): "*The question for the court is, did the Secretary of State ask himself the right question and take reasonable steps to acquaint himself with the relevant information to enable him to answer it correctly?*".
>
> 100. The following principles can be gleaned from the authorities:
>
> (1) The obligation upon the decision-maker is only to take such steps to inform himself as are reasonable.
>
> (2) Subject to a *Wednesbury* challenge, it is for the public body, and not the court to decide upon the manner and intensity of inquiry to be

undertaken (*R(Khatun) v Newham LBC* [2005] QB 37 at paragraph [35], per Laws LJ).

(3) The court should not intervene merely because it considers that further inquiries would have been sensible or desirable. It should intervene only if no reasonable authority could have been satisfied on the basis of the inquiries made that it possessed the information necessary for its decision (*per* Neill LJ in *R (Bayani) v. Kensington and Chelsea Royal LBC* (1990) 22 HLR 406).

(4) The court should establish what material was before the authority and should only strike down a decision by the authority not to make further inquiries if no reasonable council possessed of that material could suppose that the inquiries they had made were sufficient (*per* Schiemann J in *R (Costello) v Nottingham City Council* (1989) 21 HLR 301; cited with approval by Laws LJ in (*R(Khatun) v Newham LBC (supra)* at paragraph [35]).

(5) The principle that the decision-maker must call his own attention to considerations relevant to his decision, a duty which in practice may require him to consult outside bodies with a particular knowledge or involvement in the case, does not spring from a duty of procedural fairness to the applicant, but from the Secretary of State's duty so to inform himself as to arrive at a rational conclusion (*per* Laws LJ in *(R (London Borough of Southwark) v Secretary of State for Education (supra)* at page 323D).

(6) The wider the discretion conferred on the Secretary of State, the more important it must be that he has all relevant material to enable him properly to exercise it *(R (Venables) v Secretary of State for the Home Department* [1998] AC 407 at 466G)."

Sales J and CA in Das

168. The construction and application of the phrase *"suffering from a serious mental illness which cannot be satisfactorily managed within detention"* in Chapter 55.10 EIG was extensively analysed at first instance and in the Court of Appeal in *R (Das) v SSHD* [2013] EWHC 683 (Admin) and [2014] EWCA Civ 45.

169. At first instance, Sales J held at [42]-[45] that the Secretary of State did not consider the application of the policy in Chapter 55.10 EIG adequately because she did not take reasonable steps, either before or during Ms Das's detention, to inform herself sufficiently about Ms Das's mental health so as to make an informed judgment about whether the policy applied to her. Sales J nevertheless held that the Claimant would have been detained in any event and awarded only nominal damages.

170. The Court of Appeal held that Sales J had applied too high a threshold test for the applicability of Chapter 55.10 EIG when stating (in ([61] of his judgment) that the term *"serious mental illness"* connoted *"a serious inability to cope with ordinary life, to the level (or thereabouts) of requiring in-patient medical attention or being liable to be*

sectioned under the Mental Health Act 1983". The Court of Appeal went on to allow the Claimant's appeal, and remit the matter, on the basis that it was unable to conclude that the error of law did not affect the outcome of Ms Das's claim (CA [8]).

171. In the leading judgment (with which Moses and Underhill LJJ agreed), Beatson LJ, emphasised that the fact-sensitive nature of the question meant that there were limits to the detailed guidance which could be given in relation to the policy. However, with that *caveat*, Beatson LJ nevertheless helpfully went on to make a number of general points by way of useful guidance ([61]-[77]). I respectfully summarise these as follows:

(1) First, it is necessary for the Secretary of State to consider whether the policy in Chapter 55.10 EIG applies to the case of an individual whose detention is being considered.

(2) Second, the threshold for applicability of Chapter 55.10 EIG is that the mental illness must be serious enough to mean that it cannot be satisfactorily managed in detention. Satisfactory management meant considering matters such as the medication being taken, the facilities at the detention centre and whether the detainee's demonstrated needs are such that they can or cannot be provided in detention. Beatson LJ highlighted the case of *R(OM) v. SSHD* [2011] EWCA Civ. 909 which showed that some of those suffering from significant adverse effects from mental illness may be managed appropriately in detention (CA [67]).

(3) Third, where Chapter 55.10 EIG does apply, there is a high hurdle to overcome to justify detention *i.e.* the *"very exceptional circumstances"* test. The balancing exercise described in *R (Anam) v. SSHD* [2009] EWHC 2496 (Admin) [52]-[54] included, in the case of foreign national prisoners ("FNP"), taking into account the risk the FNP posed to the public (CA [68]).

(4) Fourth, whether or not the policy in Chapter 55.10 EIG is strictly engaged, as part of the operation of the *Hardial Singh* principles, particular care is needed in assessing whether to detain a person known to have a mental illness, *i.e.* consideration as to whether particular arrangements will be needed for the detainee's welfare and to monitor for deterioration (CA [69]).

(5) Fifth, the Secretary of State is not entitled to abdicate her statutory and public law responsibilitites to the relevant health authorities or clinicians in the way deprecated by Singh J in *R (HA (Nigeria)) v. SSHD* [2012] EWHC 979 (Admin) at [155] and [181] (CA [70]).

(6) Sixth, whilst it was not necessary to determine the issue in the present case, it was doubtful that the framers of Chapter 55.10 EIG meant that a detainee's mental illness could not be satisfactorily managed in detention unless specific treatment which could improve the detainee's condition was made available in detention (CA [71]).

Findings of facts in Das

172. The facts in *Das* were described by Beatson LJ as *"stark"*. He highlighted, in particular, (a) the awareness by the Secretary of State's officials in general terms of a psychiatric report about Ms Das at the time of her detention, (b) the actual receipt of that report by those responsible for Ms Das's detention when she was detained, (c) her frequent attendance at the health centre, (d) the fact that she was prescribed *Risperidone* (an anti-psychotic drug), and (e) the fact that, despite this, the reviews of Ms Das's detention did not consider or review her psychiatric condition (CA [66]).

173. In order to appreciate the starkness of the facts in *Das,* and the *gravamen* of Sales J's decision on the facts, it is necessary to set out the section of his judgment where he deals with the *Tameside* issue under the heading *"Breach of duty of inquiry"*:

> "42. Having adopted a policy regarding detention of persons suffering from serious mental ill-health, the Secretary of State was in my view under a public law obligation to take reasonable steps to give practical effect to that policy, bearing in mind the importance of the objective which it was designed to promote (namely, the humane treatment of individuals who suffer from serious mental ill-health). That means that if there was a real (as opposed to a fanciful or insubstantial) possibility that an immigrant facing removal was suffering from serious mental ill-health which could not be effectively managed while in detention, the Secretary of State had an obligation to take reasonable steps to inform himself sufficiently about the relevant circumstances so as to be able to make an informed judgment whether the policy would have application or not in that individual's case: see *Secretary of State for Education and Science v Tameside Metropolitan Borough Council* [1977] AC 1014, 1065B per Lord Diplock ("…did the Secretary of State ask himself the right question and take reasonable steps to acquaint himself with the relevant information to enable him to answer it correctly?").
>
> 43. In my judgment, the Secretary of State breached this obligation of inquiry at the outset of the second period of detention. His officials in the decision-making unit at the UKBA knew that there was in existence a psychiatric report in respect of the Claimant (Dr Sharma's report) which might well have a bearing on the question whether she was suffering from serious mental ill-health and whether she could properly be taken into detention. However, they failed to obtain Dr Sharma's report from the judicial review team, as I find they could and should have done. They thereby failed to take reasonable steps open to them at the time to inform themselves properly about those issues.
>
> 44. In my view, that failure extended throughout and affected the whole of the second period of detention. The significance placed on Dr Sharma's report on behalf of the Claimant was re-emphasised when it was sent to the decision-making unit on 22 November 2011, but no-one in the unit reviewed it for the purposes of assessing whether it was right to continue to detain the Claimant; nor did they seek to pass it on to the medical staff at the detention centre to assist them in their assessments of the mental health of the Claimant. There were significant indications from what the Claimant said and did when she was first detained and from what was found in her possession (medication and

> letters for psychiatric appointments) that her mental health could be a serious issue. The Secretary of State would be looking to the medical staff at the detention centre for on-going assessment of the Claimant's mental state, and in the circumstances ought to have provided them with relevant information in his possession which was so clearly germane to that assessment as Dr Sharma's report, which might have a bearing on their advice back to him. (Incidentally, I note that - although this was not known to the officials in the decision-making unit - there were remarks in the medical notes in respect of the Claimant during her detention making it clear that the medical staff would have liked more background information about the Claimant: they had unsuccessfully sought to obtain her medical records from her GP).
>
> 45. I consider that this failure of inquiry by the Secretary of State so undermined the proper application of his policy as to render the whole of the second period of detention of the Claimant unlawful. "

174. In the light of Sales J's strong findings of fact highlighted above, it is unsurprising that he concluded there had been had been a clear breach of the *Tameside* duty in that case.

Sales J and Beatson LJ's orthodoxy

175. I do not read paragraph 42 of Sales J's judgment as intending to lay down some special *Tameside* test or gloss, let alone a gloss which was heterodox. Read as a whole, it seems to me Sales J was merely seeking to articulate orthodox *Tameside* in this context, namely, that the decision-maker had to take reasonable steps to inform him or herself sufficiently to be able to make an informed decision. Further, by highlighting that there must be "*a real… possibility*" of serious mental ill-health, Sales J was merely emphasising the obvious, namely that a *Tameside* duty to make further inquiries would only arise where the decision-maker was put on reasonable inquiry in the first place.

176. Further, I do not think that the Court of Appeal in *Das* read Sales J's judgment in any different way. In my view, Beatson LJ was merely putting the flipside of *Tameside* when he said at [70]:

> "However, where (unlike the present case) the Secretary of State through the UKBA officials has conscientiously made reasonable inquiries as to the physical and mental health of the person who is being considered for detention, has obtained such reports of clinicians who had previously treated the person as have been made available, and considered the implications of the policy in Chapter 55.10 for the detention of that person, leaving aside cases in which there has been negligence by the clinicians at the detention centre, she should generally be entitled to rely on the responsible clinician: see, albeit in the context of the European Convention of Human Rights, *R (P) v. Secretary of State for Justice* [2009] EWCA Civ. 701 at [49]-[50]."

177. In my view, both Sales J and Beatson LJ were merely echoing the straightforward, pragmatic, context-specific approach to the *Tameside* question seen in previous cases, *e.g., R (HK (Turkey) v. SSHD* [2007] EWCA Civ 1357. In *HK(Turkey)*, the Court of Appeal held that, absent any independent evidence of torture, mere assertion of torture could not be sufficient to render a case unsuitable for the fast track procedure (whether or

not a Rule 34 examination had been carried out) ([24]-[25]). I do not accept the Claimant's submission that *HK (Turkey)* is irrelevant because it only involved short periods of detention. The approach and principles are the same.

178. If I am wrong about the above, and Sales J was laying down a specific *Tameside* test in the Chapter 55.10 EIG context, I would respectfully disagree with such an approach and suggest it was not adopted or approved by the Court of Appeal. In my view, no bespoke *Tameside* test is required in this, or any other similar context. *Tameside* is a generic and flexible public law principle which should not be trammelled. It has its *genesis* in the English Common Law principle of 'fairness' (*c.f. R(Plantagenet Alliance Ltd) (supra)* at [84] ff.). Its application is assuredly context and fact-specific. The touchstone of *Tameside* is that the decision-maker only has to take such steps to inform him or herself as are *reasonable* in the particular circumstances of the case at the time.

179. I prefer to base my approach on orthodox *Tameside* as enunciated by Beatson LJ in paragraphs [69]-[70] of *Das.* Further, it to be noted that Beatson LJ referred to the Secretary of State obtaining reports of clinicians who had previously treated the detainee *"as have been made available"* (see the passage from paragraph [70] of his judgment cited above). He did so deliberately, in my view. He was clearly referring to existing reports which had come into the possession of the Secretary of State which would inform the scope of the duty to enquire. I agree with Ms Anderson that the duty to enquire cannot be 'distorted' to require the Secretary of State routinely to generate fresh 'independent' experts reports (see further below).

The Claimant's case fails on an orthodox view of Tameside

180. The nub of the Claimant's case, as formulated by Mr Bowen QC and Ms Knorr applying their view of Sales J in *Das*, was as follows: where there is evidence that is available to the Secretary of State that a person is suffering from a mental illness that may fall within Chapter 55.10, the information relevant to the decision to detain includes the person's medical records and an up-to-date psychiatric assessment and report as to the person's mental illness and the application of Chapter 55.10.

181. In my judgment, the Claimant's case founders on this single blanket proposition. As explained above, it is far too broad a proposition and does not accord with the true view of *Tameside*. If the Claimant's proposition was correct, then in every case in which there was a mere *possibility* that a detainee, or potential detainee, *might* be suffering from a mental illness which *might* trigger Chapter 55.10 EIG, the authorities would be obliged (a) to conduct a full trawl of all the person's medical records, including confidential medical records, and (b) to procure a full up-to-date psychiatric assessment on that person, *whether or not* these steps were in fact necessary to determine the application or non-application of 55.10 EIG. This is, in my view, clearly incorrect in law and, in any event, would be unworkable and wasteful. The decision to detain is made on a case-by-case basis. I repeat that *Tameside* requires the decision-maker to make only *reasonable* inquiries as to the potential detainees physical and mental health (See Beatson LJ in *Das* at [70]). In many cases, the question of the possibility of the application of 55.10 EIG will be capable of early and easy resolution without resort to wasteful and unnecessary archaeology into all the detainees's medical records or procuring full-blown medical reports. Each case depends on its own facts. I repeat that *Tameside* only requires the

scope of inquiries to be reasonable and proportionate, *i.e.* tailored to the instant case and question. The duty to inquire is not at large or not open-ended.

182. The absurdity of the Claimant's approach can be demonstrated when applied to the rest of 55.10 EIG. Logically, if the Claimant's approach is correct, then the same *modus operandi* should apply to each of the bullet points in 55.10 EIG. Accordingly, the authorities would be obliged *ex hypothesi* to conduct a blanket evidence-gathering exercise in relation to all those with potential age issues, medical conditions, disabilities *etc*., to obviate any risk that the condition might not be capable of being satisfactorily managed in detention. This would render Chapter 55.10 unworkable. It would also involve a considerable waste of public resources. To borrow the words of Beatson LJ in *Das* at [71], I strongly doubt whether the framers of the policy intended the policy to have such an effect.

The Claimant's case fails on the facts

183. In any event, the Claimant's case also founders on the simple facts of the case. When admitted to Harmondsworth IRC, the Claimant was know to have some mental problems, including depression, for which he had been receiving treatment and medication for the previous two years. Throughout his time at Harmondsworth IRC the Claimant was given regular GP appointments and his condition was regularly monitored and appropriate treatment given. When, as a result of the intervention by Dr Robinson in July 2011, a suggestion was raised that the Claimant might have a more serious mental condition, the healthcare team set up an appointment with a consultant psychiatrist (Dr Burrun) who examined the Claimant in August 2011 and determined that the Claimant's condition was such that it could continue to be satisfactorily managed in detention. This proved in fact, to be the case. The Claimant's condition was adequately managed in detention (see further below).

Breach of Rule 34

184. The third legal issue between the parties relates to the question of Rule 34 examination. Rule 34 of the Detention Centre Rules provides that every detained person *"shall be given a physical and mental examination by the medical practitioner… within 24 hours of his admission to the detention centre"*. Rule 34 links with Rule 35, which requires a doctor to report to the manager of an IRC an individual whose health may be injuriously affected by detention.

185. The Claimant's submissions can be summarised as follows:

(1) On the facts, no Rule 34 examination of the Claimant took place within 24 hours of his arrival in detention at IRC Harmondsworth. He was seen by a nurse during his health care induction but was not examined by a GP. But for a brief examination by a GP on 31 December 2010 when he was prescribed medication for gastritis, the Claimant was not seen by a GP in Harmondsworth until 28 April 2011 and was not examined by a psychiatrist from Harmondsworth until 20 August 2011.

(2) On the law, a failure to provide the Rule 34 examination itself renders the detention unlawful because a breach of Rule 34 of the Detention Rules 'bears on' the detention and renders the detention unlawful: *per* Burnett J in *R (EO) v SSHD* [2013] EWHC 1236 (Admin) (who declined to follow Haddon-Cave J in *R (Belkasim) v. Secretary of State for the Home Department* [2012] EWHC 3109 (Admin)).

186. Ms Anderson objected to this ground on the basis that it did not form part of the Claimant's pleaded Grounds (and hence was not covered in the witness evidence) and permission was not given for it. It is fair to say that the Rule 34 argument was only first raised in the Claimant's skeleton dated 24 May 2014. However, since the matter has been fully developed in argument and the issues are ones of law and the interpretation rather than of primary fact (which do not appear to be materially in dispute), it seems to me appropriate to admit it.

Analysis – the law

187. On the law, I can say without hesitation that, having had the benefit of reading studying Burnett J's magisterial analysis in *EO* of *R (Lumba) v SSHD* [2011] UKSC 12 and *R (Kambadzi) v SSHD* [2011] UKSC 23 and Rules 34 and 35 (at [28]-[40] and [49]-[52]), I respectfully agree with his conclusion that breach of Rule 34 will render a detainee's detention unlawful because it 'bears on' the decision to detain in the sense dictated by the majority in *Lumba*. I also respectfully agree with him that my decision on this point in *R (Belkasim) v. Secretary of State for the Home Department (supra)* at [121]-[126], that breach of Rules 34 and 35 without more did not render detention unlawful and the detainee must prove causation, is wrong. As Burnett J correctly observed at [52], causation is relevant to the question of whether a claimant should be entitled to compensatory damages but not to the *anterior* question of the lawfulness of detention itself.

188. Ms Anderson relied on the doctrine of *stare decisis* (as deployed in *e.g. MN(Tanzania)* [2011] 1 WLR 3200) and submitted that my decision in *Belkasim* cannot be said to have been 'obviously wrong'. I am afraid that Burnett J's compelling *exergesis* in *EO* shows that my somewhat brusque decision on the point in *Belkasim* was obviously wrong. Burnett J was, with respect, obviously right not to follow me. (I console myself with the thought that Burnett J may have had the benefit of fuller argument on the point).

Analysis – the facts

189. On the facts, Ms Anderson submitted that the health assessment conducted by a nurse on the Claimant's entry to detention amounted to a valid Rule 34 assessment. I disagree. Rule 34 is quite explicit in requiring *"a physical and mental examination"* of detainees on admission by a *"medical practitioner"*. The reference to *"medical practitioner"* is clearly a reference to a doctor, not a nurse. As Burnett J pointed out at paragraph [49] of *EO*, a Rule 34 examination is supposed to be *in addition* to the routine medical screening which is conducted by nursing staff on admission. In my judgment, the routine health care induction given to the Claimant on his admission to Harmondsworth IRC by a nurse did not amount to a Rule 34 examination. It was not a *"physical and mental examination"* in any real sense. Nor was it an examination carried out by a "*medical practitioner*". Nor does does not pass muster, as Ms Anderson suggested, as being a medical examination by someone of a 'different grade' (*c.f. Lumba* at [68]). The routine medical screening carried

out by a nurse on admission was altogether something qualitatively quite different from a physical and mental examination by a doctor.

190. Ms Anderson argued that it was an 'adequate' assessment in the sense that it could have led to a Rule 35 referral if the nurse had noticed anything to contraindicate detention at that stage. In my view, however, this is no answer in law to the separate plain requirements of Rule 34. Rules 34 and 35 are cumulative not alternative. Nor does the fact that the Claimant was already in custody and being transferred from HMP Bullwood Hall to Harmondsworth IRC dilute the requirement of Rule 34 to conduct a medical examination on admission to the IRC. A rule change would be required to give effect to this.

191. For the above reasons, therefore, in my view, the failure of the immigration authorities to carry out a Rule 34 medical examination of the Claimant on admission to Harmondsworth IRC within 24 hours of his admission on 21 December 2010 meant that his detention from that point of time was unlawful. His detention did not remain unlawful, however, because a Rule 34 examination was carried out some 5-6 weeks later (see further below).

Causation

192. I turn, however, to the question of causation, *i.e.* whether or not, even if a requisite Rule 34 examination of the Claimant had been carried out on 21 December 2010, this would have affected the decision to continue to detain the Claimant. In this case, the answer is 'No'.

193. In *EO*, Burnett J said as follows:

> "53. In the light of the Secretary of State's acceptance of the materiality of Rule 34, the conclusion dictated by Lumba is that if an immigration detainee, in the absence of good reason, is not medically examined within 24 hours of his arrival at a detention centre, his detention thereafter will be unlawful. That is not to say that there is scope for a multiplicity of actions against the Secretary of State on this narrow ground. There is no reason to suppose that Rule 34 medical examinations are not usually conducted within 24 hours. Because the legality of detention is concerned with compliance with the Secretary of State's policy (and not with a direct breach of the Rule) a good reason for non-compliance would save the legality of detention. The Rule 34 examination is, in the context of a decision to detain, but a stepping stone to a Rule 35 report. If no Rule 35 report were raised when a medical examination did take place (albeit late) then it would follow that the decision to detain would have been the same."

194. As will be seen from the above chronology, on 1 February 2011 the Claimant was briefly transferred to Colnbrook IRC where a healthcare induction was conducted at Colnbrook IRC followed by a GP appointment. The Claimant also signed a routine disclaimer allowing the Colnbrook IRC healthcare team to disclose relevant information regarding his medical conditions, history or mental heath to named entities including the UKBA whilst in the establishment, *i.e.* Colnbrook IRC. The Claimant was returned to Harmondsworth IRC the same day, on 21 February 2011. A Rule 34 examination thus

took place some 5-6 weeks later after his first admission to IRC detention. At no stage, however, did it result in a Rule 35 referral being made.

Nominal damages

195. It follows, therefore, subject to any further findings below, that the failure to conduct a Rule 34 examination on 21 December 2010 was non-causative, *i.e.* would have made no difference to the Claimant's continued detention. The Secretary of State would not have released the Claimant in any event (*c.f. Lumba, supra*). Accordingly, the Claimant is only entitled to nominal damages for the period during which the Claimant's detention was unlawful by reason of the failure to carry out a Rule 34 examination, *i.e.* from 21 December 2010 to 1 February 2011.

'Imputation' of public law errors to the Secretary of State

196. The fourth legal issue raised by the Claimant related to 'imputation' of public law errors. The Claimant contended that a breach by the detaining authority (or its agent or employee or a private contractor employed by it) can be 'imputed' to the Secretary of State such as to render a decision by the Secretary of State to detain an individual unlawful. As authority for this proposition, the Claimant relied upon the following citations of authority which it was submitted could not be said to be clearly wrong: *R(HA Nigeria)) v. SSHD* [2012] EWHC 979 (Singh J), §§ 155, 170, 181; *R(S) v SSHD*, [2011] EWHC 2120 § 221 (David Elvin QC); *R (EH) v SSHD* [2012] EWHC 2569 (Admin), §152 (Lang J); *S v SSHD* [2014] EWHC 50 (Thornton QC), § 274. The Claimant further submitted that the Supreme Court in *Woodland v. Essex County Council* [2013] UKSC 66 regarding non-delegable duties was a 'game-changer' and reinforced the Claimant's imputation argument.

197. Ms Anderson submitted that the Claimant's submission - that any breach of public law by those practically concerned with an individual's detention at the detention centre can be 'imputed' to the Secretary of State in a manner that makes it legitimate to strike down the decision to detain - was erroneous in law. I agree. The authorities cited by the Claimant cites do not support the (novel) proposition that any breach by others can be 'imputed' to the Secretary of State in a manner that can give rise to a claim in damages for unlawful detention (as opposed, *e.g.*, to a claim for medical negligence in a private law tort). The following points are pertinent.

198. First, Singh J in *HA(Nigeria)* is authority for the opposite to that for which the Claimant contends. Singh J expressly declined to visit the errors of others on the Secretary of State and found that it was the Secretary of State's own decision dated 1 February 2010 which was flawed by her own public law error. The case essentially involved allegations of medical negligence by the responsible clinicians. There was no 'imputation' of public law errors to the Secretary of State. Any errors were not *public* law errors in any event.

199. Second, *S v SSHD* [2014] 2120 (Admin) concerned Article 3 ECHR. The case did not involve the 'imputation' of public law errors such as to render detention unlawful. In so far as it may be said to have implied there was scope for 'imputation' in the context of Article 3 ECHR, it is to be doubted since the Deputy Judge does not appear to have had the benefit of the Court of Appeal's decisions in *P* [2009] EWCA Civ 701 and *MD(Angola)* [2011] EWCA Civ 1238.

200. Third, I do not read HHJ Thornton QC's decision in *S* [2014] EWHC 50 (Admin) as purporting to lay down a principle of 'imputation' of public law errors. In so far as it does speak of a 'duty of care', however, it is to be doubted since it is well established that there is no duty of care in relation to carrying out public law functions.

201. Fourth, the passage from *EH* [2012] 2569 at paragraph [152] is referring to a (disputed) imputation of confidential medical information, not the imputation of a public law error. In the latter regard, in my judgment, it is clearly wrong (for the reasons given below).

202. Fifth, Beatson LJ made it clear in paragraph 70 of *Das (supra)* that the Secretary of State is generally entitled to proceed on the basis that duties will be performed competently (consistent with the 'principle of regularity').

203. Sixth, public law requires the Secretary of State to exercise the power to detain reasonably on the basis of what is reasonably within her knowledge at the time. It does not require perfect foresight or perfection in every aspect of decision-making.

204. Seventh, the fact that matters may not turn out to be as they were reasonably considered to be at the time of decision does not allow a decision to be held unlawful retrospectively. Hindsight has no place in deciding unlawful detention claims (*c.f. Hussein* [2009] EWHC 2506 at§ 105 upheld in *MH* [2011] EWCA Civ. 1112; *Shehasdeh* [2013] CSOH 139; *AA(Afghanistan)*[2012] EWCA Civ. 1383 and [2013] UKSC 49).

205. For these reasons, the Claimant's proposition that public law errors by the detaining authority may be 'imputed' to the Secretary of State is not good law.

'Imputation' of knowledge to the Secretary of State

206. The fifth legal issue raised by the Claimant related to 'imputation' of knowledge. The Claimant contended that knowledge of healthcare staff employed by the detaining authority or a private contractor about a detainee's condition could be 'imputed' to the Secretary of State. In support of this proposition, the Claimant relied on Lang J's judgment in *R (EH) v. SSHD* [2012] EWHC 2569 (Admin) [150]-[153] and [156].

207. In my judgment, the Claimant's proposition is wrong and pays no regard to context. Detention Centre Rules, in particular Rules 34 and 35, form part of a general system of checks and balances for the regular monitoring of detainees and ensuring that relevant information as to their mental and physical condition is brought to the attention of the SSHD in a timely fashion (as I said in *R (Belkasim) v. Secretary of State for the Home Department* [2012] EWHC 3109 (Admin) at [35]).

208. It is clear that when assessing whether to detain a person known to have a mental illness particular care is needed: the Secretary of State, through her officials, should consider whether particular arrangements should be made to monitor a detainee's welfare or for signs of deterioration (see Beatson LJ in *Das* at [69]). If, however, the Secretary of State has fulfilled her duty to ensure that suitable particular arrangements are in fact put in place for detainees with particular needs, in my judgment, it is not necessary (or appropriate) as a matter of public law that knowledge of all healthcare staff in the system is then automatically 'deemed' to be that of the Secretary of State. There are three reasons for this. First, the Secretary of State is generally entitled to rely on medical

professionals to fulfil their duties (*c.f. Das*). Second, individual acts of negligence by medical professionals do not generally give rise to a breach of the duty of the Secretary of State under Article 3 or 8 ECHR (*c.f. MD (Angola)*). Third, the 'imputation' of knowledge would violate of the fundamental duty of confidentiality axiomatic to the clinician-patient relationship and run counter to *inter alia* to: (i) the ECHR duty of confidentiality (*Z v Finland* ECHR ruling 22009/93 [1997] at § 95); (ii) domestic statutory rules on medical clinician-patient confidentiality, (iii) data protection law, (iv) contractual obligations to maintain medical confidentiality; and (v) the professional duties in relation to confidential medical information which the Strasbourg Court found were essential to underpin patient confidence in the medical profession.

209. For these reasons, I reject the Claimant's proposition that knowledge of healthcare staff may be 'imputed' to the Secretary of State. And to the extent that it is supported by Lang J in *EH*, I would respectfully decline to follow *EH.*

PRINCIPAL FINDINGS OF FACT

210. My principal finding of fact are as follows:

(1) First, the evidence and opinion of Dr Burrun is to be preferred to that of Dr Robinson and Dr Basu, *viz.* whilst the Claimant's condition may have included depression, a diagnosis of paranoid schizophrenia is doubtful. As Dr Burrun pointed out, HMP Bullwood Hall treated the Claimant for depression with possible psychotic *symptoms* not for a psychotic *disorder*.

(2) Second, at no stage was the Claimant's mental condition such that it could not be satisfactorily managed in detention and, therefore, Chapter 55.10 EIG was never engaged. It is noteworthy that even Dr Basu accepted that the pharmacological management of the Claimant's condition *could* have been satisfactorily managed in detention (see his report dated 26 June 2013).

(3) Third, at all material times the Claimant's mental condition was *in fact* adequately managed in detention, *viz.* the Claimant was given regular GP appointments and his prescriptions adjusted (see Dr Burran's report).

EXPERT EVIDENCE

Dr Robinson's report of 9 July 2011

211. The Claimant relied heavily on Dr Robinson's report of 9 July 2011. I was, however, unimpressed with it. It seemed curiously pre-disposed to achieving a finding favourable to the Claimant's case, *i.e. "psychosis… which cannot be effectively diagnosed or managed in a detention centre"*. His conclusion that the Claimant "*does not appear to be receiving adequate treatment in detention"* was, moreover, superficial and made without any apparent examination of the detailed medical records.

212. Dr Robinson may have led himself into thinking that the fact that the Claimant had been prescribed Olazapine in the past, indicated that the Claimant was suffering from

psychosis. However, as the Claimant himself explained in one of his medical assessments at HMP Bullwood Hall, he had been prescribed Olanzapine by his GP in the past for agitation and aggression.

Dr Burrun's examination on 20 August 2011

213. Following Dr Robinson's intervention on behalf of Medical Justice on 9 July 2011 claiming that the Claimant had 'a psychotic disorder', the Claimant was seen on 20 August 2011 by the relevant IRC Consultant Psychiatrist, Dr Burrun, who satisfied himself that the Claimant was not suffering from any serious psychotic problems. In his report for the Court dated 14 March 2014, Dr Burrun stated as follows regarding his examination of the Claimanton 20 August 2010:

> "Mr K reported to be suffering from depression since 2008. DK reported feeling better since restarting tablet Olanzapine 5 mg daily on the 07.07.11. DK reported that the voices were less intense and less frequent. … He said that his appetite varies and he has been sleeping properly. He denies harbouring any feelings of self-harm or harm to others. He denied experiencing any psychotic symptoms and objectively there was no evidence of DK responding to any kind of internal stimuli. DK said that he had bail hearing on 21.08.11. He was happy to continue taking his prescribed medication and he was offered One to One Counselling session with the Psychiatric nurse as well as further Psychiatric clinic follow up."

214. There was then suitable follow up by the psychiatric nurse on 6 September 2010 who reported 'no current issues'.

Dr Basu's first and second reports 19 October 2011 and 16 April 2013

215. The Claimant's also relied upon the first and second reports of Dr Basu dated 19 October 2011 and 16 April 2013. Dr Basu examined the Claimant on 5 October 2011 and produced a first report on 19 October 2011 diagnosing the Claimant with schizophrenia and criticising the Harmondsworth IRC healthcare team for the care given to the Claimant. His second report repeated these findings and stated that the Claimant's condition could not be satisfactorily managed in detention and again criticising the Harmondsworth IRC healthcare team for the care given to the Claimant whilst in detention.

216. I do not accept Dr Basu's evidence that the Claimant was suffering from a serious mental condition that could not satisfactorily be managed in detention.

217. I found both reports unsatisfactory and lacking objectivity. They both appeared to be the inevitable product of a string of leading questions formulated and posed by the Claimant's solicitors, Messrs Wilson. In relation to the first report, Wilsons posed no less than 25 questions for Dr Basu including for *e.g.* "Whether my client is delusional…?", "Is my client taking the appropriate dose of Olanzapine? If so, why does my client still appear to be psychotic/ have delusions?" *etc.*

Misconceived approach

218. The Claimant's approach to the medical evidence in this judicial case has been misconceived. This is not a private law medical negligence case. Permission for judicial

review proceedings was given to bring a public law claim in relation to alleged breaches by the Secretary of State of her immigration detention policy. Under basic administrative and public law principles, the reasonableness of decision-making is to be judged by reference to the information available to the decision-maker *at the time* of the impugned decision. In my view, Dr Basu's first and second reports are not properly directed to the main question as to whether the decision by the Secretary of State to detain, or to continue to detain, under 55.10 EIG could be considered irrational or *Wednesbury* unreasonable or in breach of *Tameside* duties on the basis of the information reasonably available at the time. Instead, they seem primarily aimed at launching an *ex post facto* attack on the responsible healthcare team and Dr Burrun's diagnosis and treatment of the Claimant and (in the second report) criticising the general medical facilities at the Harmondsworth IRC on the basis of an HM Inspector of Prison's Reports of 2010.

219. The Claimant also seeks to criticise Dr Burran for not dealing with the Claimant's experts' critiques of him. However, that is not the role of the responsible clinician in a judicial review. Dr Burran is not an 'expert' instructed by the Secretary of State in a legal negligence claim. He is merely the independent responsible clinician giving purely factual evidence as to what steps were taken at the time with regard to the care of a detainee and why.

Public and private law proceedings

220. I am not alone in deprecating the attempts to turn the judicial review procedure into a private law recovery procedure, contrary to the CPR. In *R (Brendankemp)* [2013] EWHC 2480 (Admin), Dingmans J highlighted the distinction between public law questions raised by judicial review (which are concerned with the legality of decisions and not their merits) and private law proceedings. He pointed out time-consuming and expensive Part 18 information requests (such as I understand were also deployed in this case) should were very rarely used in judicial review proceedings and drew attention to *"[the] principled differences between proceedings by way of judicial review and ordinary litigation"*.

221. I agree with Ms Anderson that, if condoned, the Claimant's approach to this sort of expert evidence would have potentially wide-ranging deleterious effects, both in relation to the conduct of other judicial reviews and the ability of the authorities to persuade NHS consultants to provide care to detainees.

The Claimant's medical records

222. The Claimant's medical records for 2010 at HMP Bullwood Hall are illuminating. His medical assessment on 6 June 2010 recorded the Claimant (i) saying that he found hearing his late father's voice telling him to 'stay out of trouble' comforting rather than distressing; (ii) stating there was no known family history of physical or mental problems; (iii) reporting that he had been treated for depression for two years by his GP but denying experiencing any mental health problems previously; and (iv) stating that he had been prescribed Olanzapine because of agitation and aggression, but he was better able to control his temper.

223. These statements undermine Dr Robinson's and Dr Basu's reports. This latter answer undermines Dr Basu's answer to the one of Claimant's Solicitors' (Messrs Wilsons) leading questions put to him, namely: 'Would a Psychiatrist prescribe Olanzapine to a

patient who did not have psychosis, *i.e*. would a patient who had been diagnosed with depression be prescribed with Olanzapine?'. In his report dated 19 October 2011, Dr Basu said that 'Olanzapine is an antipsychotic drug that is only licenced for use with schizophrenia or mania' and it is 'not indicated for a patient suffering solely from depression'.

224. The Claimant Care Assessment by South Essex Partnership University NHS Foundation Trust dated 6 June 2010 concluded:

> "[D] was appropriate throughout the assessment, he maintained good eye contact and was able to answer questions concisely. There was no evidence of response to psychotic phenomena, no was there evidence of thought disorder, insertion, ideas of reference or bizarre beliefs. His emotions and behaviour were congruent to the situation and no concerns were raised.
> [D] is due for release in six weeks and I have advised him to remain on his medication until he can speak to his GP about reducing it. He agreed with this.
> There was no evidence for any further input from In-Reach; for closure."

225. I have carefully read and considered the Claimant's medical records at Harmondsworth IRC (a summary of the entries appears in the chronology). The records form a coherent sequence. In my view, they demonstrate regular and diligent monitoring of the Claimant and his needs throughout his period of detention at Harmondsworth IRC. They do not suggest the Claimant was someone with serious mental problems, let alone that he was someone whose 'serious' condition was being ignored by the system. On the contrary, the records suggest the healthcare team were responsive in a timely way to the Claimant's various complaints, *e.g.* feeling bullied and stressed, and requests for changes in his medication. This was despite the Claimant feeling free to attend or miss GP appointments at will and being capable of being deeply offensive: when the Claimant was advised by the GP on 10 May 2011 to approach the UKBA because the bullying problem was not a medical problem the Claimant remarked "*this Indian is fucking useless"*.

226. It will be apparent from the above that the Claimant's claim is bound to fail on both the factual and expert evidence. I nevertheless turn to deal in detail with the *plethora* of grounds raised by the Claimant.

GROUNDS

Ground 1: unlawful detention: issues to be determined on the evidence

'First period' of detention: 12 December 2010 to 19 May 2011

Stage 1

Was the detention lawful?

227. Mr Bowen QC and Ms Knorr submit on behalf of the Claimant that the first period of detention, between 12 December 2010 to 19 May 2011, was unlawful on six grounds. I consider each of these *seriatim* below (even though this involves some repetition).

(i) Claimant's 'real possiblity' test

228. First, the Claimant contends that there was a 'real possibility', on the evidence available to the Secretary of State, that the Claimant fell within Chapter 55.10 EIG before and at the time the decision to detain, in particular (i) a letter from the Claimant's GP dated 10 August 2009, and (ii) extravagant claims made in his asylum interviews might be indicative of continuing mental illness such as that described by the Claimant's GP.

229. I reject this ground on the law and the facts. It is based on a misconceived view of the law, namely a misunderstanding of Sales J in *Das* (see above). In any event, on any view of the *Tameside* test in this context, there was insufficient material to put the Secretary of State on further inquiry at the time, let alone suggest that the Claimant was suffering from a serious mental illness which could not be satisfactorily managed in detention. The matter must be judged on the basis of the material available to the Secretary of State at the time, not with hindsight. The material relied upon by the Claimant does not begin to pass any sort of threshold test. The GP's letter in question was dated over 16 months before the Claimant's admission to IRC detention. The Claimants' claims to have had a successful family business in Cyprus and access to substantial funds do not in any way undermine the conclusion of the caseworker in the GCID Case Record Sheet:

> "DK is 38 and 10 months of age, believed to be in good health, apart from some mental health issues that a Doctor confirmed he was suffering from in 2008. In 2010 he was suffering from depression, but there is nothing to indicate that DK is not well at present."

230. It is clear from *LE (Jamaica) v Secretary of State for the Home Department* [2012] EWCA Civ 597 *and OM (Nigeria) v Secretary of State for the Home Department* [2010] EWHC 2147 (Admin) (both approved of in *Das)* that even those with much more debilitating serious mental illnesses with current adverse effects did not engage Chapter 55.10 EIG. In *LE(Jamaica)* the detainee suffered from very serious schizophrenia. In *OM(Nigeria)* the detainee suffered from very severe depression rendering the individual suicidal. There was no evidence before the Secretary of State (or the treating clinicians) in this case that the Claimant has been diagnosed with, or was suffering from, a psychotic illness, let alone one that could not be managed satisfactorily in detention.

(ii) 'Duty to obtain 'independent' psychiatric report'

231. Second, Mr Bowen QC and Ms Knorr argued that, in the light of the evidence under (i) above, and applying *Tameside*, the the Secretary of State have obtained further information, in particular the Claimant's medical records from the community and HMP Bullwood Hall together with an 'independent' psychiatric assessment and report as to the Claimant's mental illness before, or within a reasonable period after, the decision to detain.

232. This argument fails because of my finding on the facts that there was insufficient evidence to put the Secretary of State on further inquiry, even on the Claimant's view of the *Tameside* test in this context (see above). In any event, the argument is circular. Mr Boyd QC and Ms Knorr argue that the question whether the Claimant's mental illness was so 'serious' it could not be satisfactorily managed in detention could only be answered by 'up-to-date' medical evidence from a qualified psychiatrist, with access to medical records from the community and HMP Bullwood Hall. This begs the question

whether there was sufficient material to put the Secretary of State on reasonable inquiry in the first place. There was not.

233. I should make it clear, however, that I do not accept that there is a duty on the Secretary of State to obtain an 'independent' medical report, in the sense apparently contended for by Mr Bowen QC and Ms Knorr, namely independent from the UKBA.

234. In any event, even if (contrary to the above) the Secretary of State had a legal obligation to obtain the Claimant's confidential medical records or an 'independent' expert psychiatric report regarding the Claimant, it would have made no difference to the decision to detain in this case. It is clear from the prison medical records that the Claimant was referred for examination to the 'In-Reach' team in prison but discharged without any follow up on the basis that his mental health was stable and he did not display any evidence of psychosis. The Claimant's case based on the obtaining of unspecified 'independent' Psychiatric Consultant's reports is essentially speculative.

(iii) 'Failure to pass on information'

235. Third, Mr Bowen QC and Ms Knorr argue that the UKBA's failure to pass information from HMP Bullwood Hall relevant to the Claimant's mental illness to UKBA on form IS91RA to Harmondsworth IRC rendered the detention unlawful.

236. This is a makeweight point. The omission was not causative. The missing information in question was simply the fact that, whilst the 'psychiatric disorder' box had been ticked on the IS91RA, this had not been transferred to the IS 91 Detention Authority. However, during his health care induction, the Claimant gave the mental health nurse all the relevant information, *viz.* that (i) he had been suffering from depression since 2008 for which had been taking citalopram and Olanzapine, (ii) he had considered throwing himself in the Thames in 2008, and (iii) he wanted to see a psychiatrist. Thus, the fact that the Claimant had suffered from psychiatric problems had already been noted (see above). There was no, however, indication or information provided by the prison that the Claimant was suffering from a psychotic illness which contra-indicated detention.

237. It should be noted that the point was not pleaded, nor had permission, nor was it explained how a failure to transmit the information about the ticked box rendered the detention unlawful. It was not a public law error, nor one which could bear on the decision to detain in the relevant sense. Neither was it shown how this 'failure' would have had any effect even if full medical records had been available. It is clear that the same decision to detain would have been made in any event. These sort of points underscore the general lack of merit of the Claimant's case.

Confidential medical information

238. I accept Ms Anderson's general submission that the usual system for passing confidential medical information from responsible clinician to responsible clinician applies in detention as in the community. Accordingly, aside from the usual statutory and professional duties on responsible clinicians, the primary healthcare providers are under a contractual obligation to obtain records with consent through Rules 34-36 of the Detention Service Operating Standards Provision. As recorded in the agreed chronology, the responsible clinicians at the IRC received the Claimant's detailed medical notes on 18

November 2010 prior to the transfer of the Claimant on 21 November 2010. These records included the previous medical records obtained by the prison healthcare services.

(iv) 'Failure to act on information at medical screening'

239. Fourth, Mr Bowen QC and Ms Knorr argue that the failure to refer the Claimant to a psychiatrist in the light of the disclosure by the Claimant during his medical screening interview, that he was taking Olanzipine and wished to see a psychiatrist, rendered the detention unlawful. They submit the Claimant should have been be seen by the GP, either as part of the Rule 34 report process or independently of that process, such that a referral to a psychiatrist could be pursued.

240. I do not accept that the mere failure to accede to a detainee's request to see a psychiatrist renders detention unlawful. As stated above, the usual process of referral from primary care clinicians to the NHS Consultant secondary care specialists applies in detention as in the community. It is a matter of clinical judgment for the primary care clinician as to whether intervention by a consultant is needed and when. The Secretary of State is not involved in such clinical judgments. It should be noted that, again, this point was not pleaded as an independent ground to render detention unlawful. Nor did it have permission. In my view, it does not amount to an arguable public law breach.

(v) 'Failure to conduct a Rule 34 examination'

241. Fifth, Mr Bowen QC and Ms Knorr argue that the failure to conduct a Rule 34 examination renders the detention unlawful. I have set out my conclusions on this point above, namely, that (i) there was a failure to carry out a Rule 34 examination within 24 hours of the Claimant's admission to Harmondsworth IRC on 21 December 2010 which rendered the detention unlawful (until 1 February 2011 when a Rule 34 examination was carried out at Colnbrook IRC); (ii) however, since no Rule 35 referral would have been made, the Claimant's damages for this period would be nominal.

(vi) 'Failure thereafter to consider the Claimant's mental illness, or obtain further information'

242. Sixth, Mr Bowen QC and Ms Knorr argue that there was a failure thereafter to consider the Claimant's mental illness, including obtaining further information from Harmondsworth IRC, at the monthly detention reviews up to, and including, 18 May 2011. They point to the fact that the monthly reviews make no reference to consideration being given to the Claimant's mental illness under Chapter 55.10 EIG or any requests for further information being made. They also suggest that UKBA failed to pass relevant information pertaining to the Claimant's mental health to Harmondsworth (including GP records and delusional letters received from the Claimant).

243. These submissions have little weight, however, in the light of the regular medical monitoring the Claimant was in fact receiving throughout his detention. It is clear from the medical records that, far from being ignored, the Claimant's condition and reported symptoms were being regularly and appropriately monitored and treated. The Claimant was given GP appointments on a regular monthly or bi-monthly basis. The Claimant chose to attend some appointments and not others. He was prescribed various anti-depressants. His condition and prescriptions were regularly reviewed. Symptoms association with depression are commonly found amongst detainees. His condition did

not present as particularly serious or difficult to treat. At all material times, his medical condition was in fact being properly managed in detention.

244. I am unimpressed by the Claimant's point that no express reference was made to the Claimant's psychiatric in the Claimant's monthly detention reviews. There was no particular reason why the monthly detention reviews should have made special note of the Claimant's medical condition or why 'further information' should have been sought regarding the Claimant's condition. There is no reason why specific mention should have been made of the Claimant's fairly routine medical needs that were being adequately managed on a monthly basis by the healthcare team and which were not otherwise remarkable or noteworthy.

245. In my view, there was no duty on the Secretary of State to go outside the existing regime for the provision of confidential medical information. If the Claimant or his representatives had so wished, it was open to them at any stage to ensure that confidentiality was waived and arrangements made for the Claimant's past medical records to be passed to the Secretary of State. It is instructive that they did not do so.

246. In any event, I do not accept that the disclosure of such confidential records at any stage would have made any difference to the detention decision. The diagnosis of psychotic illness was, at best, controversial and difficult. The Claimant's medical notes recorded the Claimant as presenting to the clinicians whom saw him regularly as well-kempt, orientated in place and time and able to function normally on a normal location. At no stage was he in the hospital wing or placed on open ACDT (Assessment Care in Detention and Teamwork). This is in contrast to detainees in cases such as *HA (Nigeria)) v Secretary of State for the Home Department* [2012] EWHC 979 (Admin) *(*who refused to wash for months, slept on a mattress in the toilet and was drinking out of the toilet bowl).

FTT

247. The Claimant relies upon a diagnosis of schizophrenia by Dr. Robinson and Dr. Basu, whose views were accepted by the First Tier Tribunal ("FTT") when allowing the Claimant's appeal against deportation on Article 3 grounds on 25 June 2013. The FTT Decision dated 25 June 2012, however, merely recites Dr Basu and Dr Robinson's reports without containing any analysis of the medical background or the Claimant's medical records in detention. Nor does it appear that the FTT had the benefit of any evidence from the responsible physicians or Dr Burrun. The finding of the FTT was in fact limited, *viz.* "*the medical evidence demonstrates that the appellant suffers from delusions*" (see paragraph 15 of the Reasons). It is not, therefore, a finding which take the Claimant very far. In any event, I am not bound by the findings of the FTT which I decline to adopt.

Detention in any event

248. Even if I am wrong as to the above, it is clear that the Claimant would have been detained in any event. I accept the evidence of the Executive Criminal Casework officer, Annette Doughlin, who stated as follows:

> "In this instance there was no evidence upon which I could have concluded that the Claimant was suffering from a serious

> mental illness that could not be managed satisfactorily at HMP Bellwood or an IRC. Furthermore, on submitting the IS91RA (Risk Assessment Form), to the prison and requesting that all adjudications be listed, I was aware that any serious medical issues that could not be managed by immigration detention would have been relayed back to the Home Office to take further action in terms of assessing the Claimant's suitability for continued detention. I have reconsidered the position when making this statement and I confirm that even in the light of all the information now relied on with hindsight, the exclusionary policy in Chapter 55.10 would not have been applied without substantiating evidence available to me."

249. In my view, contrary to the Claimant's interpretation, Ms Doughlin is quite clearly stating that she still would have recommended the detaining of the Claimant even in the light of the information now available (which includes the reports of the examinations by Dr Robinson and Dr Basu); and she would not have recommended he be released (excluded from detention) without appropriate evidence to substantiate her triggering the exclusionary policy under 55.10 EIG.

250. In any event, I am satisfied that the decision to continue to detain the Claimant cannot be said to be irrational or unreasonable, even in the light of Dr Robinson and Dr Basu's reports of their examinations. As Dr Burrun points out, diagnosis of these sorts of conditions by doctors can legitimately vary. Furthermore, even if the Claimant was suffering from a psychotic condition as Dr Robinson and Dr Basu suggest, I am satisfied that the Claimant's condition could be satisfactorily be managed in detention. Proof in the pudding is that the Claimant's condition *was* satisfactorily managed in detention. This is clear from the contemporaneous records themselves. There are no reports of the Claimant at any stage suffering from any serious problems or seriously deteriorating mentally.

251. Furthermore, as Beatson LJ pointed out in *Das (supra* at [67]), cases such as *R(OM) v. SSHD* [2011] EWCA Civ 909 show that some of those suffering significant adverse effects from mental illness may be managed appropriately in detention. OM had attempted suicide by hanging and was diagnosed as having recurrent depressive disorder and emotionally unstable personality disorder. The view of the experts were divided but Richards LJ stated that the balance of expert advice was that her illness could be managed appropriately in detention.

Dr Burrun's evidence

252. The Secretary of State has produced evidence from Dr. Burrun, the psychiatrist who examined the Claimant while in detention on 20 August 2010. In his report for the Court dated 14 March 2014, Dr Burrun summarised the findings of his examination of the Claimant on 20 August 2010. It is worth citing Dr Burrun's conclusions in full:

> "Opinon
>
> Mr K has been diagnosed to be suffering from Depression since 2008 following a break up of a relationship for which he was receiving treatment in the community. He gives no past history of any intervention by Secondary Mental Health services nor has he had any past Psychiatric Admission.

During his detention at Harmondsworth IRC Mr K was seen by the Psychiatric Nurse and he was also regularly seen in the GP clinic when the dose of his antidepressant medication Tablet Citalopram was gradually increased from 10 mg daily to 40 mg daily. He was reported restarting on Tablet Olanzapine 5 mg daily in April 2011 which was subsequently increased to 10 mg daily.

Mr K presentation has been inconsistent as although at times he has been reporting to hear the voice of his late father, objectively he has not been observed to be responding to any kind of internal stimuli. He has been reported to be interacting well with officers on the wing and observed to be socialising appropriately with other detainees at all times.

It is my opinion that Mr K treatment for his depression has been appropriately managed within the health care setting of Harmondsworth IRC. Transfer to hospital under Section 48/49 of the Mental Health Act 1983 (amended 2007) was not necessary.

I have considered the diagnosis given in the reports commissioned by Mr K represetatives. I do not concur with the conclusions of the reports to the effect that any potential condition of Paranoid Schizophrenia was not managed satisfactorily in detention. Paranoid Schizophrenia is not an uncommon condition, in particular amongst the prison population. It is a mental disorder that is managed satisfactorily regularly across prisons and in detention centres. I have considerable professional experience in the diagnosis and management of Paranoid Schizophrenia including in the detention context. The facilities available in a detention context are sufficient to manage the condition though they may not include all the possible specialist therapies that would be available in Psychiatric hospitals.

In my opinion, his is the type of case where diagnosis may legitimately vary as it was, at best, a doubtful case given Mr K presentation on a day to day basis where he was observed to be interacting appropriately in normal location with other detainees and officers. Mr K was also observed to be attending to all his activities of daily living appropriately.

As the medical notes (including medical notes from HMP Bullwood Hall) indicate, Mr K was treated for Depression with possible Psychotic Symptoms (NOT FOR PSYCHOTIC DISORDER) as there were many indicators consistent with this diagnosis rather than Paranoid Schizophrenia. Mr K was treated with the appropriate medication and his mental state regularly reviewed and monitored during his stay in detention. Throughout his period of detention, Mr K denied experiencing any suicidal intent or any plans of ending his life including when he was seen by me. Mr K was not a native English speaker and so sometimes expressed himself in an idiosyncratic way but I do not consider that his presentation was ever genuinely bizarre, disorientated or distracted during our interactions. There was no reported attempts at self-harm whilst he was in detention or any conduct of concern that would trigger an ACDT. Whilst it is right that Mr K reported hearing his late father's voice this seems to have occurred mostly while he was falling asleep at night which indicates that they are more likely to be pseudo hallucinations or hypnogogic hallucinations rather than psychotic in nature. There were no objective evidence [sic] that Mr K was

> observed to be responding to any kind of internal stimuli or the voices telling him to harm himself or others.
>
> Mr K did not present as having any greater level of anxiety due to situational stress than is normal for a person[] whose immigration status is uncertain. There was no evidence that detention in itself was causing or materially worsening any mental illness either from a fair reading of the contemporaneous objective evidence or based on my interaction with Mr K."

253. I accept these views and conclusions of Dr Burrun.

254. I accept his evidence that the Claimant was not suffering from a psychotic condition and, in any event, his condition was in fact managed adequately in detention. The Secretary of State was entitled to rely on the professional expertise of responsible healthcare experts who were responsible for the Claimant's care at the time.

255. As stated above, I reject the Claimant's criticisms of Dr Burrun's evidence and his assessment of the Claimant on 20 August 2011. The fact that it was a short examination does not in any way undermine his conclusions. Dr Burrun is a very well qualified and experienced Consultant Psychiatrist with particular experience in locked rehabilitation centres, prisons and IRCs. I am satisfied that Dr Burrun had Dr Robinson's report available to him when he conducted his examination of the Claimant. In any event, Dr Robinson's intervention and views were recorded on the patient notes, so Dr Burrun would have been aware of them.

256. I reject the Claimant's disingenuous attack on Dr Burrun's assessment as being 'arguably negligent' whilst acknowledging that the court could not make any specific findings of negligence without hearing from Dr. Burrun. The Claimant's attack on Dr Burrun is, in any event, misconceived. Dr Burrun's examination of the Claimant on 20 August 2011 was not for the purpose of preparing a full psychiatric report on this detainee, let alone a report for litigation. It was merely an appointment for a routine examination of a patient about whom some mental health concerns had been raised. He conducted a perfectly proper examination which he recorded in the patient's notes. He was not required to write a full report on the patient but merely make a diagnosis and satisfy himself as the condition of the patient in detention. Nor was he required to 'engage with the reasoning' of Dr Robinson (or Dr Basu) in his notes or his later statement for the court. He was one of the responsible clinicians at the IRC at the time who examined the Claimant and was merely required to explain to the Court what steps he and the IRC healthcare team took with regard to the Claimant and why. This he has done perfectly clearly and I accept his evidence.

257. The Claimant's approach is also predicated on a misapprehension: that 'satisfactory management' of a detainee's condition necessarily involves facilitating recovery not merely preventing deterioration. In so far as it is necessary to do so, I respectfully adopt the same view as that expressed by Beatson LJ in *Das* at [71] on this point when rejecting a submission by MIND, namely, that it was doubtful that the framers of Chapter 55.10 EIG meant that a detainee's mental illness could not be satisfactorily managed in detention unless specific treatment, such as counselling, which could improve the detainee's condition was made available in detention.

Admissibility of Dr Basu's third report

258. I have been asked to rule on the admissibility of a third report by Dr Basu dated 21 May 2014, which the Claimant served on 30 May 2012, only two weeks before the hearing. The Claimant contended that Dr Basu's third report should be admitted out of time under CPR 54.16 because Dr Burrun was not called to give evidence and the Claimant did not apply to cross-examine him, but instead took the 'proportionate' step of serving a supplementary report by Dr Basu responding to Dr Burrun's statement of 14 March 2014 (which itself was served late two weeks late on 24 March 2014). Ms Anderson objected to its admissibility.

259. I reject the Claimant's application to adduce the third report by Dr Basu on both procedural and substantive grounds.

260. As to procedural grounds: Dr Basu's third report was served outwith the Order for directions made on 30 October 2014. That Order only granted the Claimant permission to adduce an Addendum to Dr Basu's existing report dated 19 October 2011 (following his examination of the Claimant on 5 October 2011). It did not give the Claimant permission to serve any further report by Dr Basu, nor was a further report contemplated or envisaged. This was unsurprising in the context of judicial review which does not encourage *ex post facto* expert disputes in a case of this sort. The Order gave the Secretary of State permission to adduce any further evidence by 3 March 2014 and for the Claimant to make any application to cross-examine any witness who had filed evidence on behalf of the Secretary of State by 21 March 2014. The Order also was set the matter down for trial on 18 and 19 June 2014. I do not accept that it appropriate for the Claimant to choose to serve a supplementary report from Dr Basu under the guise of a 'proportionate' alternative to seeking to cross-examine Dr Burrun. It was disingenuous for the Claimant's advisors to suggest surprise that Dr Burrun was not called to give evidence. As Ms Anderson pointed out, no competent practitioner in the field of judicial review could have envisaged that a live witness would be called to give evidence absent an application by the other side to cross-examine. It is equally disingenuous for the Claimant to express surprise that Dr Burrun's witness statement would reflect his own medical assessment of the Claimant and not agree with Dr Robinson and Dr Basu's assessments. In any event, I do not accept that it was appropriate for the Claimant to delay a further two months to serve Dr Basu's further report, which was then served just two weeks before the trial. This was prejudicial to the other side who were given no time to respond.

261. As to substantive grounds: it seems to me, on reading Dr Basu's third report *de bene esse*, that it is inappropriate and unsatisfactory for similar reasons to those I have articulated in relation to his first and second reports (see above). His third report is not properly directed to the public law questions arising from 55.10 EIG but seeks inferentially to attack the responsible healthcare team and Dr Burrun's diagnosis and treatment of the Claimant and criticises the facilities at the Harmondsworth IRC on the basis of HM Inspector of Prison's Reports in 2010.

262. For these reasons, I refuse the Claimant's application to admit the third report of Dr Basu.

Stage 2

Would the Claimant have been detained in any event?

263. The Claimant appeared to contend for four public law errors: (i) First, errors on a basis of the Claimant's *Tameside* test, in particular the Secretary of State failed to obtain further information in response to the GP note showing a past history of depression/IS91RA note. (ii) Second, the Secretary of State failed to pass on the information in the IS91RA to healthcare. (iii) Third, alleged medical negligence by the primary care clinician for not referring the Claimant immediately to the NHS Consultant on entry to the IRC. (iv) Fourth, failure to comply with Rule 34.

264. In my judgment, as explained above, only one public law error is made out: the failure the comply with Rule 34. However, as set out above, a Rule 34 examination was conducted on 1 February 2011 and no Rule 35 referral was made. It is clear, therefore, that the Claimant would have been detained in any event (see above). Accordingly, the breach of Rule 34 was non-causative and sounds only in nominal damages.

265. I should make it clear that, in my judgment, the first three alleged public law errors would not pass the 'but for' *Lumba* test either (assuming, *ex* hypothesi, these were public law errors at all). It is quite clear, in my view, that the Secretary of State would have detained the Claimant in any event, and could lawfully have done so. This is clear from the contemporaneous and witness evidence which show that the responsible clinicians did not consider that the Claimant was suffering from a serious mental illness that could not be managed satisfactorily in detention. This is an opinion which Dr Burrun still holds, notwithstanding the Claimant's materials. Further, it was lawfully open to the Secretary of State to detain under the section 36(1) power and then s 36(2) absent the alleged public law errors. It would not have been irrational or unreasonable to have done so on the evidence then available.

Were there exceptional circumstances justifying detention in any event?

266. In view of my finding that the Claimant's detention was not unlawful, it is not necessary to determine the second question, namely, were exceptional circumstances justifying detention in any event? However, I turn deal with this issue briefly since it was argued.

267. I direct myself that where the policy Chapter 55.10 does apply, the 'exceptional circumstances' test is a high hurdle to overcome to justify detention (*per* Beatson LJ in *Das* at [68]).

268. In my judgment, the Secretary of State would be able to satisfy the test in this case. First, the Claimant was a Foreign National Offender ("FNO") with a history of offending and was, therefore, accordingly some way across the 'spectrum approach' in *Anam v Secretary of State for the Home Department* [2010] EWCA Civ 1140 when weighing the public interest against the individual interest in avoiding any suffering (albeit his index offence was a less serious offence with the guidance in Chapter 55.3A EIG). The Claimant's point (again raised after the hearing) that the Court should place weight on the fact that the Claimant was not recommended for deportation by the criminal court is misconceived. The Automatic Deportation regime simply removes the Secretary of

State's discretion to determine whether deportation is 'conducive to the public good'. Accordingly, deportation recommendations are not sought in FNO automatic deportation cases (though occasionally the courts still make them of their own motion despite being of no effect since the FNO must be deported if it is lawful to do so). Second, in my view, the Claimant represented a clear risk of absconding since he had absconded before in 2007 (notwithstanding that Chapter 55.1.3 EIG recognises that a person who has an appeal pending may be more like to comply with conditions if released). Third, the effects of continuing detention on the Claimant were not such as to lead to significant suffering (over and above the inherent ordinary adverse effect of any detention on most individuals as recognised in the Article 3 ECHR jurisprudence).

'Second period' of detention: 19 May 2011 to 21 October 2011

269. In view of my findings regarding the first period of detention, I can see no basis on which the Claimant can succeed in relation to (what is called) the 'second period' of detention. It is not alleged that, *e.g.*, the Claimant's condition suddenly deteriorated in the second period to a state where it could not be satisfactorily managed in detention and *ergo* the Claimant should have then been released. The thrust of the Claimant's case has been that the Claimant was suffering *ab initio* from a mental condition which could not be satisfactorily managed in detention. I have rejected that case for the reasons set out above. The same reasons apply *mutatis mutandis* to the second period.

270. Nevertheless, I turn to consider *seriatim* the further grounds argued by the Claimant in relation to the second period in case there is some differentiation.

(i) Tameside

271. The Claimant's contends that the Secretary of State came under a 'fresh' *Tameside* duty once she was informed of the First Tier Tribunal's concerns regarding the the Claimant's possibly delusional behaviour at the asylum appeal on 17 May 2011 and a public law error is disclosed because the Secretary of State should have proceeded to obtain a mental health assessment (as requested by the UKBA in a fax to Harmondsworth dated 19 May 2011). I disagree. In my judgment, the information that the Claimant has made extravagant claims at the immigration hearing was not such as to materially change the picture about this detainee. Nor does it give rise to a public law error bearing on detention. In any event, the response of Harmondsworth IRC to this information was timely, proportionate and reasonable: the Claimant's medical file was reviewed by the Health Care Manager at Harmondsworth IRC who responded to UKBA on 20 May 2011 that the Claimant has been seen by a GP and was stable on medication.

(ii) 'Inaccurate' fax of 20 May 2011

272. The Claimant contends that the Health Care Manager at Harmondsworth IRC's fax of 20 May 2011 was 'inaccurate' since the Claimant had not been seen by a GP since the UKBA's request was made and it was not true to say that the Claimant was 'stable on medication'. The Claimant does not, however, condescend to explain how this gives rise to a public law error, let alone one which bears on detention. In my judgment, it does not. In any event, the fax of 20 May 2011 was not self-evidently inaccurate on the information available at the time (or now): the Claimant had been seen by a GP no less than three

times in the past five weeks (on 14 and 28 April and 4 May) and the Claimant had been re-started on a course of Olanzapine. Further, the point was not pleaded and, given the passage of time, it is not necessary, possible, proportionate or fair to expect the Secretary of State to respond to factual allegations of this sort of granularity.

(iii) 'Failures to pass on information to Harmondsworth IRC'

273. The Claimant's next point is put in the following somewhat convoluted fashion: Can the Secretary of State rely on that letter for the failure to insist upon a mental health assessment until after 11 August 2011, having regard to the fact that the Secretary of State did not pass information to Harmondsworth IRC concerning (a) the evidence she had from the Claimant's GP; (b) the extravagant claims made by the Claimant in his response to deportation questionnaire and asylum interview; (c) the nature of the extravagant claims made by the Claimant at his asylum appeal, and the concerns of the judge and presenting officer that he was delusional; (d) the clearly paranoid letters written by the Claimant to the Secretary of State on 12 April 2011?

274. It appears to be an attempt to aggregate what the Claimant claims are earlier failures by the Secretary of State with regard to failures to pass information Harmondsworth IRC in order to undermine the efficacy of the 20 May 2011 message. In view of my findings above, this point has no substance. In any event, I do not accept the underlying premise that the only way in which Harmondsworth IRC would have been aware of the Claimant's complaints that his problems were being caused by a 'conspiracy' of the Home Office, police *etc* is through these channels. It is clear that he raised this sort of point (which are not uncommon allegations by detainees) with the healthcare team and others. Further, and in any event, I do not accept that the Secretary of State was entitled, let alone obliged, to disclose confidential information about the Claimant's immigration and asylum claims.

275. The Claimant sought to raise a yet further point under this head as follows: Further or alternatively, the Secretary of State's decision not to obtain a further psychiatric assessment and report at this stage was based upon a material error of fact, which itself gives rise to a breach of public law: see e.g. *R (Connolly) v Havering LBC* [2010] 2 P. + C.R. 1, Chapter §32-37, so that the decision to detain is vitiated on the grounds of unfairness. This point was neither pleaded, nor given permission, and not raised until after the hearing. In the interests of fairness, finality and proportionality, I refuse to permit the argument to be run. In any event, in view of my finding that there was no material error of fact regarding the Claimant's condition, it would appear to be of no substance.

(iii) 'Failures to pass on information to Harmondsworth IRC was public law error'

276. The Claimant next contends that, in any event, (i) the failure by Harmondsworth to pass relevant information concerning the Secretary of State's mental condition (which included two recent GP visits in which he had reported the return of the voices and had requested Olanzipine) was itself a breach of public law that bore on, and was relevant to, the detention that vitiated the lawfulness of the detention; and (ii) Harmondworth IRC's knowledge is to be imputed to the Secretary of State.

277. In view of my findings above, there is no substance in this point. I do not accept that the message of 20 May 2011 was misleading. I do not accept that there were relevant failures to pass on any material information about the Claimant's condition, or that these

could be classed as public law errors. In any event, I do not accept that any alleged public law error by the responsible clinicians may be imputed to the Secretary of State. Rule 35 only requires the Secretary of State to be informed of any mental condition that contraindicates detention. It does not require the disclosure of confidential medical information about what a patient said to the clinicians as the Claimant suggests.

(v) 'Delay'

278. The Claimant contends that a delay of five months in obtaining a psychiatric assessment of the Claimant was so unreasonable as to breach *Tameside*. I do not accept that there was an unreasonable delay in obtaining a psychiatric assessment of the Claimant. It is clear from Dr Burrun's evidence that the Claimant's psychiatric condition was being regularly and properly monitored and assessed (see above). I do not accept that it is an alleged failure to conduct an assessment by a primary care clinicians may properly be imputed to the Secretary of State. As set out above, the Secretary of State was entitled to rely on the professional judgment of the responsible clinicians as to what the Claimant's medical needs were and whether they could satisfactorily be managed in detention and on the proper operation of Rule 35 (*c.f. Das* in the Court of Appeal at [70]).

Stage 2 questions

279. The Claimant has not demonstrated either a public law error giving rise to the quashing of the decisions to detain in the Second period, or that Chapter 55.10 applies. Accordingly, the Stage 2 questions do not arise. However, in so far as necessary, I repeat *mutatis mutandis* the points made under the Stage 2 hearing in relation to the First Period (see above).

Further late evidence

280. I reject the Claimant's further application to admit yet further late evidence in the form of a statement from the Claimant's solicitor exhibiting an article from the Guardian newspaper criticising Harmondsworth IRC's record keeping in another case. This sort of evidence is irrelevant and unhelpful.

Ground 2: claims under the Human Rights Act 1998 (HRA)

Article 5

281. The Claimant further claims under the ECHR are of no substance.

282. The Claimant sought in post-hearing written submissions to maintain a claim for a declaration under Article 5 ECHR. This was surprising. The Claimant expressly disavowed Article 5 ECHR at the permission hearing and cannot properly raise it again. The Claimant's submissions on Article 5 were not pleaded or raised in opening, but referred to for the first time in the Claimant's Note of 25 June 2014. In any event, they add nothing to the case.

Article 3

283. The Claimant maintains the Secretary of State was in breach of the Claimant's Article 3 ECHR rights. The Strasbourg case law makes it clear that the refusal to release a detainee suffering from a naturally occurring mental or physical illness is not a breach of Article 3 or 8 ECHR. The heavy burden of proof on the Claimant under relation to Article 3 to establish a breach 'beyond a reasonable doubt' has not be met in this case. There was no evidence *e.g.* of systemic risk or intense suffering.

Article 8

284. The Claimant maintains that the Secretary of State was in breach of the Claimant's Article 8 ECHR rights. Article 8 ECHR rights are, however, qualified. The obligation under the ECHR is to establish and maintain a proper system of law and practice to provide healthcare to detainees. It is not a counsel of perfection. There is no basis upon which the Claimant can maintain a breach of such obligations.

CONCLUSION

285. For the reasons set out above, the Claimant's claim for damages for wrongful detention is refused on all grounds and the claim dismissed.

Postcript

286. The manner in which the Claimant's case has been argued has been unsatisfactory and costly. The Secretary of State has had to respond to an endless litany of points taken under the guise of public law errors, many neither pleaded nor properly raised, or raised well out of time. The Claimant's approach has been out of all proportion to what is at stake. I trust it will not be emulated in future cases. Both sides have been being funded by the public purse.