Neutral Citation Number: [2019] EWHC 2879 (Admin)

Case No: CO/4578/2018

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30/10/2019

Before:

MR JUSTICE CHAMBERLAIN

- -

Between:

THE QUEEN **Claimant**

on the application of

GUSZTAV KRISZTIAN GASZTONY

-and-

SECRETARY OF STATE FOR THE HOME DEPARTMEMT **Defendant**

-and-

NHS ENGLAND

Interested Party

- -
- -

Mr Raza Halim (instructed by **Fadiga & Co.**) for the **Claimant**
Ms Jennifer Thelen (instructed by **Government Legal Department**) for the **Defendant**
Mr Mungo Wenban-Smith (instructed by **Government DAC Beachcroft**) for the **Interested Party**
Hearing dates: 3 October 2019

- -

Approved Judgment

Mr Justice Chamberlain:

Introduction

1 The Claimant, to whom I will refer as GKG,[1] is a national of Hungary. He moved to the UK in 2009. Between July 2013 and December 2017, he was convicted 8 times of 12 offences. These include sexual offences – in particular, the stalking and harassing of women. GKG has autistic spectrum disorder ('ASD') and has from time to time suffered from psychotic symptoms. On 20 February 2018, he was detained under immigration powers by officers in the Nexus High Harm Case Unit. After initially being held at Gloucester Police Station, he was moved to Colnbrook Immigration Removal Centre ('IRC') on 22 February 2019. He was detained for just over 16 months at Colnbrook IRC and Harmondsworth IRCs, until 26 June 2019. On any view, that is a very substantial period.

2 This claim for judicial review, challenging the Secretary of State's decision to detain GKG and failure to release him, was issued on 16 November 2018. The relief then sought was: an order that the Claimant be released '*to a secure mental health unit within seven days*'; a declaration that his detention was unlawful; and damages, including aggravated and exemplary damages. On 1 March 2019, Mr Dan Squires QC, sitting as a Deputy High Court Judge, granted permission to apply for judicial review and expedited the claim, directing that it be heard as soon as possible after 4 June 2019. On 3 April 2019, Thornton J joined the Secretary of State for Health as an Interested Party. On 18 June 2019 Supperstone J joined NHS England, also as an Interested Party.

3 GKG was released from detention on 26 June 2019. The relief now sought is therefore backward-looking. It is limited to a declaration that GKG's detention was unlawful and damages. On GKG's behalf, Mr Raza Halim advances three grounds of challenge: first, that he was detained in breach of the Secretary of State's *Adults at Risk in Immigration Detention* ('AAR') policy; second, that his detention was in breach of the second and third *Hardial Singh* principles (*R v Governor of Durham Prison ex p. Hardial Singh* [1984] 1 WLR 704) and contrary to Article 5 ECHR; and, third, that his detention violated his rights under Article 3 and/or Article 8 ECHR. Before turning to these grounds in detail, it is necessary to summarise the relevant facts and the applicable provisions of law and policy.

The relevant facts

4 There are a great number of documents recording what was done by the Secretary of State in this case. The records of regular detention reviews and the GCID notes were diligently completed. These and the other records were helpfully summarised in a referenced chronology prepared initially by Ms Thelen but then agreed with amendments by Mr Halim. What follows is a summary of the most relevant events.

[1] No application for anonymity or reporting restrictions was made, so initials are used by way of shorthand only.

20 February to 11 July 2018

5 As noted above, GKG was detained on 20 February 2018, initially at Gloucester Police Station. He had been sleeping rough. On the day of his detention, it was noted that he had ASD and, because of that, required an '*appropriate adult*' to be present when he was interviewed. He was assessed as a 'Level 2' adult at risk under the AAR Policy. The view was taken that detention was justified in light of the immigration control factors applicable in his case.

6 On 22 February 2018, GKG was moved to Colnbrook IRC, where he was assessed by Dr Hillier, a consultant forensic psychiatrist. Dr Hillier noted that in 2013 GKG had been detained in a secure psychiatric hospital under ss. 47 and 49 of the Mental Health Act 1983 ('MHA'). He noted:

> 'History of previous decompensation of mental health in detention environment is of concern. Indicates a high risk that detention is likely to have a detrimental impact on his mental-health. His illness is not amenable to medication given its inherent nature.'

On the case record sheet, the following was recorded:

> 'His condition is not one which is amenable to treatment with medication being primarily improved by modifications to his environment.'

7 On 27 February 2018, in the light of Dr Hillier's view, GKG was re-assessed as a Level 3 adult at risk. Ms Knott of the Operations Nexus High Harm Team in her witness statement explains that it was '*not considered appropriate or reasonable to release him to no fixed abode*'. The case owner therefore began to explore a release address and contacted the Adults At Risk Accommodation Team ('AARAT'). On 1 March 2018, he was served with a Notice of Liability to Deportation, which offered him an opportunity to waive his appeal rights and return to his country of origin.

8 On 7 March 2018, information was received from Gloucestershire Police that GKG was a '*potential danger to females*'. The view was expressed that if he were released into the public domain he would re-offend quickly. On 8 March 2018, the AARAT were chased for advice on a possible release address.

9 On 14 March 2018, an urgent medical report was sought under rule 35 of the Detention Centre Rules 2001 (SI 2001/238). It was provided on 15 March 2018, again by Dr Hillier. He noted that GKG had a diagnosis of ASD and had previously been admitted to a psychiatric unit with complex mental health problems. He added:

> 'Individuals with such disorders are unable to cope for long periods with situations of detention other than for therapeutic purposes and with special adaptations to take account of their vulnerabilities.
>
> …

> As his mental state deteriorates and he is increasingly withdrawn and expressing evidence of low mood in the context of his developmental disorder I am of the view that detention is having a detrimental impact on his mental-health.'

The rule 35 report form then asked:

> 'Can remedial action be taken to minimise the risks to the detainee's health whilst in detention? If so, what action and in what timeframe?'

Dr Hillier answered as follows:

> 'Remedial efforts have been made in terms of caring for him off the main wing, as well as to report him to the Local Safeguarding Team, although treatment of his mental health problem of a pervasive developmental disorder is a highly specialist area.'

The form then asked:

> 'If the risks to the detainee's health are not yet serious, are they assessed as likely to become so in a particular timeframe (ie in a matter of days or weeks, or only if detention continued for an appreciably longer period)?'

Dr Hillier responded:

> 'I would consider that the time frame for deterioration is gradual but present in the (2-3 weeks period [*sc* since GKG was detained]) and I am mindful of previous unexpected and rapid deteriorations during a previous custodial episode.'

10 The rule 35 report prompted an *ad hoc* detention review on 19 March 2018. (Article 5 ECHR requires detention to be regularly reviewed; and the Secretary of State's policy prescribes the points at which such reviews must be carried out and the levels of seniority of the reviewer. Reviews other than at the prescribed points are referred to as *ad hoc* reviews.) The review on 19 March 2018 said this:

> '[GKG] has been assessed as an adult at risk level 3 given the medical reports and advice received from the IRC. His medical is being closely monitored. If removal cannot be effected within a reasonable timescale or his conditions deteriorate the submission may be considered to release. This was previously considered but [GKG] could not provide a release address. Further medical information has now been received and it is deemed [GKG] should be released from detention. His health and vulnerabilities mean he cannot be released to no fixed abode therefore Schedule 10 accommodation has been requested. Once sourced it is considered [GKG] should be released from detention. Meanwhile, his conditions can be monitored in the IRC.'

11 On the same day a request was made to the Criminal Casework Accommodation Team in the Home Office ('CCAT') for Schedule 10 accommodation. (This is accommodation

provided, exceptionally, by the Secretary of State pursuant to Schedule 10 to the Immigration Act 2016, rather than by a local authority.)

12 On 22 March 2018, the CCAT assessed GKG as not meeting the criteria for Schedule 10 accommodation. The reasons for this were explained as follows:

> 'While it is considered that [GKG] has been diagnosed with Autism Spectrum Disorder, as an EEA national, he has the ability to access public funds and seek the appropriate care from the NHS.
>
> His Rule 35 report was assessed by our independent medical advisor who did not assess that [GKG] was unable to leave the UK.
>
> There is a charity called Shelter who have ties to local authorities who may be better able to assist with sourcing accommodation for [GKG].'

13 On the same day (22 March 2018), the Secretary of State made and served on GKG a decision to make a deportation order and GKG's detention was re-reviewed. The reviewing officer considered the presumption of liberty, but concluded that this was outweighed by the need to protect the public from the risk of harm and to maintain effective immigration control. Reference was made to GKG's offending behaviour. So far as his mental-health was concerned, the following was said:

> '[GKG] has been assessed as an Adult at Risk (level 3) given the medical reports and advice received from the IRC. His mental-health is being closely monitored. If removal cannot be effected within a reasonable time scale, or his conditions deteriorate, a release submission shall be considered. [GKG's] health and vulnerabilities means he cannot be released to no fixed abode therefore Schedule 10 accommodation has been requested. Once sourced, it is considered [GKG] should be released from detention.'

The reviewer continued as follows:

> '[GKG] has been assessed as posing a high risk of harm, high risk of reoffending and high-risk of absconding. The only barrier to his removal is a signed Deportation Order. [GKG] has 14 days in which to lodge an appeal against his Decision to Make a Deportation Order. Should he fail to appeal, a signed deportation order can be obtained imminently.
>
> Therefore, it is considered that removal is achievable within a reasonable timescale and that detention is justified and proportionate.'

The authorising officer, who was required to countersign the review, said this:

> 'Continued detention authorised whilst schedule 10 accommodation is sourced and accepted.
>
> I am satisfied that [GKG's] medical requirements are best served with this course of action rather than releasing to no fixed abode.

Consequently detention justified.'

14 On 5 April 2018, GKG lodged an appeal against the Secretary of State's decision to make a deportation order.

15 On 10 April 2018, GKG's solicitors had said that they had contacted both Shelter and Mind but they were unable to locate accommodation. The solicitors had also requested hospital accommodation. These points were considered on 11 April 2018, but it had already been decided at a Complex Case conference on 5 April 2018 that GKG did not meet the criteria for admission to hospital. Consequently, a second request was submitted to CCAT for Schedule 10 accommodation.

16 On 19 April 2018, there was a further Complex Case Healthcare Teleconference. The team agreed to explore other avenues of accommodation. On the same day there was a further review of GKG's detention. The authorising officer said this:

> 'This is a challenging case. The individual is subject to deportation proceedings and he has been served with a Decision to Make a Deportation Order against which he has launched an appeal. Travel documentation is not a bar to removal but the in country appeal is a potential long-term barrier. The subject has severe mental health issues and is deemed to be an Adult at Risk Level 3. Now that the subject has launched an appeal we are faced with a long-term barrier to removal. However, in order to affect effective release we need to source an appropriate address and as yet we have been unable to resource a suitable address or engage the provisions under Schedule 10. Given the fact that deportation is proceeding and we are awaiting the dates of the appeal I am willing to authorise immigration detention for a further 14 days while we seek to secure an appropriate address to securely release.'

17 On 20 April 2018, further medical evidence was submitted to the CCAT in an attempt to persuade it to reconsider its refusal of Schedule 10 accommodation. Further attempts to chase CCAT are recorded on 25 and 26 April and 1 May 2018. On 2 May 2018 CCAT agreed to provide a self-contained address because they were now satisfied that GKG met the criteria because of his mental-health requirements.

18 On 3 May 2018 there was a further detention review. The authorising officer said this:

> 'This individual remains subject to deportation proceedings and the barrier to removal remains the ongoing appeal. While we hold valid travel documentation and consider the subject's known offending a threat to the public we are aware of the prolonged appeal and the potential impact continued detention could have on the subject's mental health.
>
> We are continuing to pursue suitable accommodation to release the subject to and we have made progress with the CC Accommodation Team who had now agreed to source an address which is preferable to release to the street. I am advised that the case-owner will have an update on this address on 9 May so I am content to authorise immigration detention for a further 14 days while we seek to make suitable arrangements to release while the in country appeal continues.'

19 On 9 May 2018, CCAT advised that an address had been requested from a property provider for a Level 2 self-contained property. On 14 and 15 May 2018, the CCAT requested an update from the accommodation provider. On 17 May 2018 there was a further detention review in which detention was authorised for a further 14 days while arrangements were made to secure an appropriate address.

20 On 23 May 2018 the CCAT said that they had approached another accommodation provider. On 31 May 2018 there was a further detention review. The authorising officer said this:

> 'This is a challenging case. We continue to pursue deportation and note the pending in country appeal. This is balanced against the subject's serious health issues which render him to be deemed an Adult at Risk Level 3.
>
> Given the subject's previous conduct and ongoing health issues it is inappropriate to release him to the street. We are advised that this case is eligible for Schedule 10 accommodation and we now only wait for a suitable address to be located. Immigration detention is to be maintained for a further 14 days only while suitable arrangements to accommodate the subject are finalised.'

21 On 1 June 2018 the CCAT requested further information on GKG's healthcare needs. This was provided. On 14 June 2018 there was a further detention review in which detention was authorised for a further 14 days while suitable arrangements were made to accommodate GKG. On 21 June 2018 the CCAT proposed self-contained accommodation in Bradford and the case-owner was advised to contact relevant parties in order to gain approval to discharge GKG to this address. After chasing the police on two occasions, a response was received from the Bradford neighbourhood police team on 5 July 2018 which indicated that there was nothing to suggest that the address was inappropriate. A release submission was prepared on the same day and sent to a director in the Home Office for authorisation. The submission was, however, returned by the director seeking further information from healthcare as to the type of care that should be provided to GKG in the community. On 9 and 10 July 2018 attempts were made to liaise with the community mental health team in Bradford and to arrange transport.

22 Just at the moment when it appeared that the necessary arrangements were finally in place, two things happened. First, on 10 July 2018, GKG's appeal to the First-tier Tribunal was dismissed. Second, Dr Hillier advised that he was making an immediate referral for GKG to be transferred to a secure ward pursuant to s. 48 of the MHA. GKG's detention was reviewed again on 12 July 2018. Detention was authorised for a further 7 days, that being the period that it was anticipated would be required to arrange his admission to a secure unit.

23 The referral, which was in the first instance to the Bracton Centre, took place on 16 July 2018. Detention was authorised for a further 7 days pending transfer on 19 July 2018. On 24 July 2018 GKG lodged an application for permission to appeal to the First-tier Tribunal ('FTT'). On 26 July and 2, 9 and 16 August 2018, detention was authorised, in each case for 7 days. On 22 August 2018 it was authorised for 14 days. On the latter occasion the following comment was recorded in the detention review:

> 'concerns have been raised about the length of time it has taken to establish a suitable bed and this has been escalated to the NHS England to investigate.'

On 24 August 2018 it was noted that the reason for the delay was that there was no bed available in a facility suitable for this detainee and that this was a reflection of a chronic shortage of beds for MHA patients nationally. The point was made that the Home Office was, by comparison with the public at large, '*extremely well served*'.

24 Meanwhile, on 20 August 2018, the Upper Tribunal had granted permission to appeal. On 31 August 2018 GKG's solicitors sent a letter under the pre-action protocol threatening judicial review proceedings. A supplementary pre-action letter was sent on 11 September 2018. In their response, on 13 September 2018, the Home Office said this:

> 'The medical advice also provided is that [GKG], purely for clinical reasons, is unable to be released from detention into the community.
>
> [GKG] continues to be cared for by the IRC Mental Health Team and is current [sic] waiting for a bed at the secure unit, with whom the IRC staff are in regular contact, to become available.'

25 On 20 September 2018 detention was authorised for a further 28 days. On 4 October 2018 it was noted that the Bracton Centre had advised that a move would hopefully take place soon. It did not. It is apparent from the papers that Home Office officials were becoming exasperated by the delay. On 16 October 2018 healthcare indicated that they would be escalating this issue to the relevant NHS commissioners. On 1 November 2018 the Health Care Manager said this:

> 'The situation is unchanged I am afraid to say. As discussed at this afternoon's meeting the clinical judgement of the consultant psychiatrist attached to the centre, Bradley Hillier, remains firmly that [GKG] requires specialist treatment and MHA referral to a specific facility, Bracton Hospital in Kent. That as you know has been subject to an extremely lengthy delay. It has repeatedly being put to Dr Hillier whether another more accessible, facility might be used and each time we have received the same response that it is only this facility, Bracton, that is apparently able to provide the level of treatment and security [GKG] requires. The advice also is that he remains unfit for release.
>
> The irony of all this is of course that [GKG] has in the meantime be [sic] held in the allegedly unsuitable environment of the IRC whilst waiting for a bed at Bracton to become available. That delay has of course been unconscionable, months rather than weeks now and is, we are told, the subject of a referral to the local NHS Commissioner.
>
> What we don't have, however, is any sort of timeframe from the NHS for moving this case on. An extraordinary situation.'

26 On 2 November 2018 detention was authorised for a further 28 days. By 5 November 2018 it had become clear that the clinical team at the Bracton Centre did not now consider

GKG to be unwell enough to qualify for a bed there. On 6 November 2018 Dr Hillier reported as follows:

> 'Update of pathway: The Bracton Centre has declined to admit as he is not unwell enough to reach their threshold. It remains the view of the clinical team that he is vulnerable with his autism spectrum disorder and cannot be safely released in the UK without a package of care. I am actively pursuing NHS England to support identification of way to resolve this. At present whilst awaiting resolution I am of the view that IRC is the most appropriate place, since transitions need to be minimised and into the nature of his illness and distress this can cause.'

27 At a complex case healthcare teleconference on 8 November 2018, Dr Hillier advised that GKG was not suitable to be released into the community. That advice was repeated at a further teleconference on 15 November 2018.

28 On 16 November 2018, TKG sought interim relief in the form of an order that he be released to a secure mental health unit within 7 days. That relief was granted by Murray J on the same day subject to a liberty to apply to vary or discharge the order. On 23 November 2018, the Secretary of State did apply to discharge the order, citing Dr Hillier's view that if GKG could not be discharged to a secure hospital the *'next best alternative'* was for him to remain in immigration detention. Yip J discharged Murray J's order on the same day.

29 On 27 November 2018, there was a teleconference at which Dr Hillier explained that he had referred GKG to an autism specialist in Bristol. On 30 November 2018 detention was authorised for further 28 days. The authorising officer noted:

> 'It is clear that every effort is being made to seek alternatives to detention and I also note that, should the outcome of the UTT be received (given the hearing was on 29 October this is anticipated to be received soon), [GKG] could become removable. There is a further hearing on 4 December in relation to legal proceedings regarding detention. I agree that detention pending the outcome of the hearings, both from the High Court and UTT, and in view of the medical evidence from Dr Hillier remains proportionate and authorise continued detention.'

30 The 4 December 2018 hearing referred to was a renewed application for interim relief seeking release of GKG from immigration detention to a secure mental health unit. That application came before Mr David Edwards QC, sitting as a Deputy High Court Judge. Mr Halim, who appeared for GKG then as he did before me, was asked whether he was pressing for an order at GKG be released immediately regardless of what arrangements had or had not been made for him. The judgment records that Mr Halim make no such application. In those circumstances, the only order made by the Deputy Judge was for reports to be made by the Secretary of State to GKG's legal team and to the Court following an assessment due to be made on 10 December 2018 by Dr Toogood, a psychiatrist in Bristol, who was due to assess GKG's suitability for admission to a secure unit in the Bristol area.

31 Dr Toogood and her team (which included Dr Amy Canning, a clinical psychologist) assessed GKG on 10 December 2018 and concluded that he did not meet the criteria for admission to secure services and should instead be subject to placement by the local CCG in Gloucestershire. On 12 December 2008 the CCAT offered an address in the Bristol area. That address was approved by the local police on 14 December 2018. On 18 December 2018 guidance was sought from Dr Toogood on the suitability of the proposed address.

32 GKG's detention was further reviewed on 28 December 2019. The authorising officer said this:

> 'I am aware there is a presumption to release and the detention should only be maintained for a reasonable period. I note the complexities in this case and that the CC caseworkers are doing everything possible to ensure his release into an acceptable environment. He poses a significant risk if released without the required management of his mental-health. I particularly note Dr Hillier's statement that [GKG's] detention sees him (currently) in the 'least bad place'. I authorise a further 28 days detention to await the outcome of the JR and to enable NHS colleagues to source the requisite accommodation for [GKG].'

33 On 21 January 2019, GKG was assessed for admission to Wotton Lawn Hospital by Mr Roland Dix, a Consultant Nurse. His conclusion, which had been agreed with Dr Jim Laidlaw (Clinical Director of the 2gether NHS Foundation Trust) and discussed with Tim Maddox (a social worker in the same Trust), was as follows:

> '[GKG] provided no evidence that he was suffering from a mental disorder by nature or degree in the domain of psychiatric illness for which treatment is available at Wotton Lawn Hospital. He certainly did not to meet the admission criteria for Psychiatric Intensive Care Unit which would require an acute disturbance secondary to an acute mental disorder likely to respond to treatment in 4 weeks. Moreover, we identified no psychiatric needs that would be consistent with admission to a general adult psychiatric inpatient facility.
> …
> On the strength of our assessment of [GKG] and information from other sources, our assessment elicited no evidence that [GKG] would provide a basis for his transfer to Hospital for treatment under the provisions of Section 48 of the Mental Health Act.'

Mr Dix recommended that community providers should be further pursued with a view to release into the community once arrangements had been made.

34 Having received that report, Dr Hillier is recorded on 25 January 2019 as having come round to the view that a community placement option would be the '*next way forward with appropriate support*'. On 28 January 2019, Dr Hillier advised that arrangements were being made for a social care assessment by Gloucestershire County Council ('GCC'). On 7 February 2019, there was a further Complex Cases Healthcare teleconference at which enquiries were made about whether there had been progress with GCC. There had not. On 21 February 2019, a release referral was submitted to the

Immigration Enforcement Director proposing release once all the necessary support had been put into place. On 22 February 2019, detention was re-authorised by the director, who said this:

> 'I think we should be releasing… but I am not sure that releasing into the community is the right thing. I would welcome Dr Hillier's views on this proposed course of action. I would have thought releasing into a health environment would have been much more appropriate.'

35 On 4 March 2019 Mr Dan Squires QC, sitting as a Deputy High Court Judge, granted permission to apply for judicial review. On 6 March 2019 GCC's adult social care department assessed GKG. On 14 March 2019 there was an initial MAPPA conference to establish what support would be provided in the community. On 19 March 2019 GCC's adult social care report was received. Dr Hillier indicated that he had spoken to colleagues at Gloucestershire CCG and agreed that arrangements should be made to release GKG to Home Office schedule 10 accommodation with an escort, support from the local crisis mental-health team and from local social services.

36 On 21 March 2019 a release submission was prepared. The detention review indicated that the plan to release to a particular address in Bristol should be regarded as final and it was noted that release should take place in the earlier part of the week and definitely not on a Friday or over the weekend. This was so that appropriate support would be in place if needed immediately upon release.

37 The release submission was not approved. The authorising director required further specifics on when GKG would be released, where he would be accommodated, how he would get there and how continuity of medical care could be achieved. An urgent teleconference was held in order to establish a more concrete care plan. On 26 March 2019, Dr Hillier advised that an agreement was pending from the Bristol and Gloucestershire CCGs as to how the care required by GKG on release would be funded. At a Complex Case Healthcare teleconference on 29 March 2019, it was confirmed that agreement was still awaited.

38 On 1 April 2019 the Upper Tribunal dismissed GKG's appeal. The delay of more than 7 months between the hearing and the handing down of the decision resulted from the file being mislaid by the Upper Tribunal.

39 Between 3 and 5 April 2019 efforts were made by members of the Secretary of State's team to liaise with the relevant NHS authorities in both Gloucestershire and Bristol.

40 On 10 April 2019 GKG applied to the Upper Tribunal for permission to appeal.

41 On 11 April 2019 officials again contacted NHS authorities in Gloucestershire and Bristol. On 17 April 2019, Gloucestershire CCG reiterated its responsibility for after-care under s. 117 of the MHA but noted that there were difficulties in putting in place the necessary support arrangements for individuals who move outside of the commissioning area.

42 In a detention review on 17 April 2019, the authorising officer said this:

> 'I am aware that there is a presumption to release and that detention should only be maintained for a reasonable period of time. It is also to facilitate the removal. It is disappointing that [GKG] has not been released into the right healthcare environment. I note his UT appeal was dismissed this month and on the 25th there is a MAPPA meeting. That is some sort of progress. Bearing in mind [GKG's] vulnerability I have no apparent choice than to authorise a further 28 days detention. I hope during that period there is real progress as to his release.'

43 The MAPPA meeting referred to took place on 25 April 2019. At that meeting, the Senior Probation Officer stressed that GKG would be offered the same '*universal provision*' as anyone else with ASD receiving services from the probation team. Any requirement for crisis care would be identified at the point of need. On 3 May 2019 the Gloucestershire MAPPA administrator noted as follows:

> '[GKG] is assessed as having no mental illness, he has an autistic spectrum condition. From a Health and Social Care perspective there are no immediate needs and therefore nothing to be provided. His autism needs can be met through universal services. Dr Brad Hillier believes that there may be a need for Crisis Team support but nobody would notice until he is released. This service is, however, available to anyone, it doesn't matter where you are from. This should not be a barrier to discharge.'

44 Detention was re-authorised on 15 May 2019.

45 There was further contact between officials of the Secretary of State and Gloucester CCG on 16 May 2019, leading to a teleconference on 30 May 2019. At that conference it was confirmed again that, in the view of Gloucestershire CCG, GKG's after care needs could be met by access to universal services, though a review would be necessary within four weeks of release to determine how he was settling into his local area. The agreed plan upon release had four elements: first, register with local GP surgery; second, review by the CCG/CC within four weeks of release; third, once moved and settled, GP to refer to the local mental health team as necessary; fourth, if he is in crisis, he can access the Bristol crisis team. Those participating in the teleconference agreed that a 1 to 2 week timeframe would be optimal to ensure that GKG was informed of the discharge and transition plan and that early follow-up could be provided.

46 On 4 June 2019, a further release submission containing details confirmed in the conference on 30 May 2019 was prepared. It was considered by a director on the same day and refused.

47 There was a further detention review on 12 June 2019 in which detention was authorised for a further 28 days. On 14 June 2019, a revised release plan was prepared setting out in detail measures to mitigate risk. On 21 June 2019 (a Friday), GKG was informed of the release plan. On the same day the Upper Tribunal refused his application for permission to appeal to the Court of Appeal.

48 On 26 June 2019 (a Wednesday), GKG was released with a care plan materially identical to that agreed at the teleconference on 30 May 2019.

49 GKG has since applied to the Court of Appeal for permission to appeal the decision of the Upper Tribunal. That application has yet to be determined.

The applicable provisions of law and policy

Statutory powers to detain

50 Regulation 23(2)(b) of the Immigration (European Economic Area) Regulations 2016 (SI 2016/1052: **the EEA Regulations**) provides that an EEA national who has entered the United Kingdom may be removed if '*the Secretary of State has decided that the person's removal is justified on grounds of public policy, public security or public health'*. Regulation 32(1) provides as follows:

> 'If there are reasonable grounds for suspecting that a person is someone who may be removed from the United Kingdom under regulation 23(6)(b), that person may be detained under the authority of the Secretary of State pending a decision whether or not to remove the person other that regulation, and paragraphs 17 to 18A of Schedule 2 to the 1971 Act [the Immigration Act 1971] apply in relation to the detention of such person as these paragraphs apply in relation to a person who may be detained under paragraph 16 of that schedule.'

51 Paragraphs 17(1) of Schedule 2 confers power on a constable or immigration officer to arrest without warrant a person liable to be detained under paragraph 16 (and, by virtue of regulation 32 of the EEA Regulations, regulation 23(6)(b)). Paragraph 2(2) of Schedule 3 confers power to detain where notice has been given of a decision to make a deportation order.

Public law constraints

52 Although the powers conferred by these provisions are not on their face limited, public law imposes constraints on the manner in which they may be lawfully exercised. This is particularly so where the person being detained suffers from a mental disorder. A comprehensive summary of the various constraints imposed by statute and at common law, as they relate to detainees with mental disorders, can be found in the judgment of Hickinbottom LJ (with which Peter Jackson and Longmore LJ agreed) in *R (ASK) v Secretary of State for the Home Department* [2019] EWCA Civ 1239, at [12]-[79]. So far as relevant to this claim, these include: the duty to comply with published policy – here the AAR policy – absent a cogent reason for departing from it (which is relevant to Ground 1); the duty to exercise the statutory detention powers reasonably and for the prescribed purpose of facilitating deportation (Ground 2); and the duty imposed by s. 6 of the Human Rights Act 1998 to exercise those powers compatibly with Articles 3 and 8 ECHR (Ground 3).

The AAR policy

53 A decision-maker must follow his published policy unless there are good reasons for not doing so: *R (Lumba) v Secretary of State for the Home Department* [2012] 1 AC 245, [26] (Lord Dyson). Ms Thelen, for the Secretary of State, did not suggest that this was a

case in which there were reasons for departing from published policy. Her case was that the policy was flexible enough to accommodate the judgments made in this case.

54 The AAR policy was introduced with effect from 12 September 2016 in substitution for the policy contained in Chapter 55 of the Enforcement Instructions and Guidance (Detention and Temporary Release). There have been several iterations of the AAR policy since then, but I am assured by both Counsel that the version in force at the relevant times is identical in all relevant respects to that now in force (which is dated March 2019).

55 The AAR Policy provides as follows under the heading 'Assessment: general principles':

> 'The decision maker should answer the following questions to inform their decision:
>
> - does the individual need to be detained in order to effect removal? See Detention – general guidance.
>
> - if the answer is no, they should not be detained
>
> - if the answer is yes, how long is the detention likely to last
>
> - if the individual is identified as an adult at risk, what is the likely risk of harm to them if detained after the period identified as necessary to effect removal given the level of evidence available in support of them being at risk?
>
> If the evidence suggests that the length of detention is likely to have a harmful effect on the individual, they should not be detained unless there are public interest concerns which outweigh any risk identified. For this purpose, the public interest in the deportation of foreign national offenders (FNOs) will generally outweigh risk of harm to the detainee. However what may be a reasonable period for detention (in line with the Hardial Singh principle (*Singh, R v Governor of Durham Prison* [1983] EWHC 1 (QB)) will likely be shortened where there is evidence that detention will cause a risk of serious harm. Where the detainee is not an FNO, detention for a period that is likely to cause serious harm will not usually be justified.'

56 Under the heading 'Who is regarded as an adult at risk?', the following appears:

> 'An individual will be regarded as being an adult at risk if:
> …
> those considering all reviewing detention are aware of medical or other professional evidence which indicates that an individual is suffering from a condition, or has experienced a traumatic event (such as trafficking, torture or sexual violence), that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention, whether or not the individual has highlighted this themselves
> …

> The nature and severity of the condition, as well as the available evidence of a condition or traumatic event, can change over time. Therefore, decision-makers should use the most up-to-date information each time the decision is made about placing someone in detention, or continuing that detention.
>
> Before referring individuals to a particular immigration removal centre, decision makers must confirm that a particular centre has adequate healthcare facilities to accommodate that individual's needs. Immigration removal centres do not provide inpatient facilities and can provide primary healthcare only.'

57 The way in which decisions on detention are to be made is explained under the heading 'Assessment of immigration factors' as follows:

> 'In all cases in which detention of an individual is being considered, the decision maker deciding on detention should first assess whether there is a realistic prospect of removal within a reasonable timescale. If there is not, the individual should not be detained. In cases in which there is such a prospect, and in which the individual is determined to be at risk in terms of this policy, the decision-makers should carry out an assessment of the balance between the risk factors and the immigration factors. This should involve weighing of the evidence-based level of risk to the individual against:
>
> - how quickly removal is likely to be affected
> - the compliance history of the individual
> - any public protection concerns
>
> An individual should be detained only if the immigration factors outweigh the risk factors such as to displace the presumption that individuals at risk should not be detained. This will be a highly case specific consideration taking account of all immigration factors. In each case, however, there must primarily be a careful assessment of the likely length of detention necessary and this should be considered against the likely impact on the health of the individual if detained for the period identified given the evidence available of the risk to the individual. The likely length of detention prior to removal should be quantified in days, weeks or months and this predicted timeframe should be recorded when making detention decisions.'

58 The policy requires decision-makers to assess the evidence as falling within one of three levels. Level 2 applies where there is '*professional and/or official documentary evidence indicating that an individual is an adult at risk but no indication that attention is likely to lead to a significant risk of harm to the individual is detained for the period identified as necessary to affect removal*'. Level 3 applies in the following circumstances:

> 'Where on the basis of professional and/or official documentary evidence, detention is likely to lead to a risk of harm to the individual if detained at the period identified as necessary to affect removal, they should be considered for detention only if one of the following applies:

- removal has been set for a date in the immediate future, there are no barriers to removal, and escort and any other appropriate arrangements are (or will be) in place to ensure the safe management of the individual's return and the individual has not complied with voluntary or insured return
- the individual presents a significant public protection concern, or if they have been subject to a four-year plus custodial sentence, or there is a serious relevanct national security issue or the individual presents the current public protection concern.'

59 The policy then makes clear that:

> 'The above is intended as a guide rather than a prescriptive template for dealing with cases. Each case must be decided on its own merits, taking into account the full range of factors, on the basis of the available evidence.'

60 In *ASK*, Hickinbottom LJ said this at [54]:

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

61 At [220], Hickinbottom LJ added as follows:

> '(i) The policy refers to "those suffering serious mental illness which cannot be satisfactorily managed within detention". The focus is therefore upon management of the serious mental illness. Such illnesses by their nature can, without deteriorating as an illness, be variable in symptomatology over time; and clinicians can, quite reasonably, differ in their assessment of diagnosis, prognosis and the severity of the symptoms of which complaint.
>
> (ii) …when the Secretary of State is assessing whether a particular serious mental illness can be satisfactorily managed in a particular patient in an IRC, so long as his approach to the assessment is lawful he necessarily has a wide margin of discretion.
>
> (iii) In making that assessment, although the Secretary of State cannot abdicate his statutory and public law responsibilities, where conscientious enquiries have been made about the health of the detainee in the context of Chapter 55.10 of the EIG [the predecessor of the AAR Policy], then he is generally entitled to rely on the opinion of the clinicians or, if opinion is not unanimous, to rely upon any one of the opinions insofar as it appears sincerely and reasonably held.

> (iv) Whether an illness has deteriorated, or whether there is a risk that it will deteriorate, will clearly be an important fact in this assessment – indeed, I accept that it may usually be critical – but I do not accept that it will be necessarily decisive…
>
> (v) …As Beatson LJ said in *VC* at [65], "periods of calm are not necessarily indicative… of a mental health condition being satisfactorily managed…"; but, in my view, the opposite is also true. A conclusion that an illness cannot be satisfactorily managed in detention cannot be drawn from merely the fact that there is an increase in severity of symptoms. It may be that that increase is just a manifestation of a variable condition; or that a change in medication will reduce the symptoms again, and such a change would be well within the scope of satisfactory management of the condition. The crucial question is a broader one, namely, as put by Dyson LJ in *M* at [39], "whether facilities for treating the person whilst in detention are available so as to keep the illness under control and prevent suffering" (i.e. suffering that would not have to be endured if the individual was being treated out of detention).
>
> (vi) However, the Secretary of State cannot shut his eyes to the variations in a person's condition as reflecting his illness by failing to monitor the individual's condition thereby risking a deterioration to a point where the illness cannot be managed. Therefore, at least on initial detention and at the regular detention reviews, there is an obligation on the Secretary of State to be alert to signs of (e.g.) deterioration that indicate the illness is not being satisfactorily managed *(R (BA) v Secretary of State for the Home Department* [2011] EWHC 2748 (Admin) at [183]-[184] as approved in *VC* at [52]). Wherever a detainee has a serious mental illness, Chapter 55.10 is engaged to that extent.'

Hardial Singh and Article 5 ECHR

62 The *Hardial Singh* principles are conveniently set out by Lord Dyson in *Lumba* at [22]:

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

63 At [115] in the same judgment, Lord Dyson noted that the application of these principles was '*fact specific*' and that those principles should not be applied '*rigidly or mechanically*'.

64 In this case, and subject to one caveat, there is no dispute that the detention complied with the first and fourth of these of the *Hardial Singh* principles. The argument focused on the second and third. The caveat is that, in the course of his oral submissions in reply,

Mr Halim drew my attention to *R (AA) v Secretary of State for the Home Department* [2010] EWHC 2265 (Admin). At [40] of his judgment in that case, Cranston J held:

> 'The use of immigration detention to protect a person from themselves, however laudable, is an improper purpose. The purpose of the power of immigration detention, as established in *Hardial Singh* and subsequent authorities, is the purpose of removal.'

Mr Halim disavowed any attempt to impugn the detention in this case on the ground that it was effected for an improper purpose. As Ms Thelen pointed out, no such ground of challenge had been pleaded. Mr Halim's point was a different one: at points, the argument for the Secretary of State had seemed to pray in aid GKG's own interests in justifying the decisions to detain; and reliance on those interests was in principle impermissible.

65 It is now well-established that the *Hardial Singh* principles must be applied '*upon the basis of what was known to the Defendant's officers at the relevant time, not with the benefit of hindsight*': *R (Botan) v Secretary of State for the Home Department* [2017] EWHC 550 (Admin), [93] & [96], citing *Fardous v Secretary of State for the Home Department* [2015] EWCA Civ 931 at [42].

66 In *R (M) v Secretary of State for the Home Department* [2008] EWCA Civ 307, [39], Dyson LJ held as follows:

> 'I accept that, if it is shown that a person's detention has caused or contributed to his suffering mental illness, this is a factor which in principle should be taken into account in assessing the reasonableness of the length of the detention. But the critical question in such cases is whether the facilities for treating the person whilst in detention are available so as to keep the illness under control and prevent suffering.'

67 In *ASK*, at [59], Hickinbottom LJ cited this passage with approval. At [60], he gave this gloss, which is relevant to the application of the third *Hardial Singh* principle:

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

At [231], Hickinbottom LJ addressed the position of a detainee requiring mental health treatment in hospital:

> 'In my view, even where the Secretary of State is satisfied that, because of the requirement for treatment in hospital, there is no real prospect of removing the detained person within a reasonable time, the Secretary of State is not bound immediately to release the person into the community to fend for himself and/or in the hope that he might (voluntarily) attend hospital or do something to provoke an order under section 2 or 3 of the MHA 1983. The person is still liable to be removed; and, in the circumstances of this case, in my view it is open to the Secretary of State to keep a person detained and safe for a reasonable time pending transfer to hospital (initially under section 48 or by some other mechanism) even in circumstances in which, if he were to remain in an IRC without the prospect of such transfer, the *Hardial Singh* principles might be breached. That does not seem to me to be a wrong or abusive use of the power to detain under the Immigration Acts; and the argument that it *is* wrong or an abuse seems to me to cast the *Hardial Singh* principles too rigidly.'

68 Where a requirement for transfer to a mental hospital has been identified, it is not enough for the Secretary of State to sit back and wait for a bed to become available. Once there are reasonable grounds to believe that a detainee requires treatment in a mental hospital, she is under a duty expeditiously to take reasonable steps to obtain appropriate medical advice, and if the advice confirms the need for transfer to a hospital, to take reasonable steps within a reasonable time to effect that transfer. The steps that are reasonable will depend on the circumstances, including the apparent risk to the detainee if no transfer is effected: *R (HA (Nigeria) v Secretary of State for the Home Department* [2012] EWHC 979 (Admin), [169] (Singh J), applying in the context of immigration detention the principle enunciated in *R (D) v Secretary of State for the Home Department* [2005] 1 MHLR 17 (Stanley Burnton J). On the facts of *HA (Nigeria),* a delay of over 5 months in arranging a transfer to a mental hospital was '*manifestly excessive*'. In *ASK*, the first instance Judge (Green J) found no breach of the AAR Policy or the *Hardial Singh* principles arising from a delay of just over 2 months: see [2017] EWHC 196 (Admin) at [9(ix)-(x)] in transferring the detainee to hospital after the point at which the Secretary of State concluded that there was no proper basis for removal. That was because '*it would be wrong and illogical to conclude that in a relatively marginal or unclear case, characterised by a divergence of expert opinion, the Defendant had to treat the case as one of such compelling and overriding urgency that a hospital bed needed to be secured forthwith, i.e. immediately*': see at [188]. The scarcity of mental health resources was a factor that could also be taken into account: [191]-[192]. By implication, in a case that is *not* marginal or unclear and where there is no divergence of medical opinion, it may be incumbent on the Secretary of State to arrange transfer more quickly or even immediately. The Court of Appeal upheld this reasoning on the particular facts of *ASK*'s case: see [2019] EWCA Civ 1239 at [233].

69 The cases considering the Secretary of State's obligations to arrange medical treatment for detainees with mental health problems have, to date, been ones where what is required is transfer to a mental hospital. But I can see no reason of principle why any different approach should apply in a case where what is required is the provision of a support package necessary to enable a detainee to live independently in the community. In each

case, the availability of a willing clinical team is a precondition for the treatment to be given. In each case, the Secretary of State plays a part in co-ordinating and making the necessary arrangements and can take steps to influence the priority and urgency to be given to the making of those arrangements.

70 There is no material difference between the constraints imposed by Article 5(1) ECHR and those imposed by the common law: *ASK*, [61]-[62].

The statutory framework governing the commissioning and provision of healthcare and its implementation in this case

71 Section 1H of the National Health Service Act 2006 ('NHSA') created the body known as NHS England. Responsibility for the commissioning of healthcare – *i.e.* for arranging for the provision of healthcare services by procurement and contracting – lies with NHS England and the Clinical Commissioning Groups ('CCGs'). The services are provided by bodies commissioned to do so under contract with a CCG or with NHS England. These bodies are generally NHS Trusts and NHS Foundation Trusts. A helpful summary of the duties of CCGs (which is equally applicable to NHS England when it commissions healthcare services) may be found in the judgment of Stuart-Smith J in *R (JF) v NHS Sheffield Clinical Commissioning Group* [2014] EWHC 1345 (Admin). For present purposes, it is relevant that the Commissioner's duty is to arrange for the provision of healthcare services only to the extent that it considers necessary to meet the reasonable requirements of the persons to whom it has a responsibility. What counts as a reasonable requirement may be determined by reference, among other things, to resources: *ibid.*, [43(ii)].

72 Under s. 3B(a)(c) NHSA and reg. 10 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (SI 2012/2996), NHS England has responsibility for commissioning healthcare services (which include adult secure mental health services) for persons detained in IRCs. CCGs, however, are responsible for commissioning local mental healthcare provision.

73 The contract for the provision of healthcare at Colnbrook and Harmondsworth IRCs was awarded to Central and North West London Foundation Trust, which provides what NHS England describes as a '*comprehensive, integrated, multi-disciplinary healthcare service, including in relation to mental health*'.

Articles 3 and 8 ECHR

74 It is uncontroversial that conditions of detention (including a failure to give a detainee appropriate medical treatment and/or transfer him when in need of hospital treatment) may result in his suffering inhuman or degrading treatment within the meaning of Article 3: *ASK*, [67]. However, the courts have consistently stressed that, in order to reach the threshold necessary to engage Article 3, the suffering and humiliation involved must go beyond that inevitable element connected with a given form of legitimate treatment (here, detention for immigration purposes): *HA (Nigeria)*, 174(5); *ASK*, [68]-[69]. Whilst the focus is on the effects of treatment on the individual, the standard is objective: *ASK*, [70]-[71]. A claimant bears the burden of '*conclusively establishing*' that the treatment he has suffered reaches the relevant threshold, which may (but need not) connote a standard of

proof higher than the usual balance of probabilities: *ASK*, [73]. Article 3 may also impose a positive obligation on the state to take measures designed to ensure that treatment reaching the threshold is not suffered: *ASK*, [74(i)].

75 The focus of Article 3 is very different from that of Article 8. It is wrong in principle to consider that an Article 3 claim can be treated in the alternative as an Article 8 claim, with the latter simply having a lower threshold. That said, mental health is a crucial part of an individual's integrity and thus private life, so that acts which have a detrimental impact on an individual's mental health may interfere with the individual's Article 8 right. However, the state's interest in deporting foreign national criminals falls squarely within the categories of public interests which may justify an interference with the right.

GKG's submissions

76 Mr Halim emphasised that the claims alleging breach of the AAR Policy and violation of the *Hardial Singh* principles overlapped. Nonetheless, he dealt with these grounds in turn. The following is a broad summary of his submissions, which are considered in further detail under the heading 'Conclusions'.

Ground 1: Breach of the AAR Policy

77 In oral submissions Mr Halim criticised the Secretary of State for unexplained or unjustified delay at several points in the chronology. At my invitation he prepared a short note after the hearing identifying the periods of inaction and summarising the criticisms made in respect of each period. The periods on which he concentrated in the supplementary note were: 28 February to 8 March 2018; 15 to 19 March 2018; 22 March to 11 April 2018; 4 to 12 July 2018; 12 July to 6 November 2018; and 21 January to 26 June 2019.

Ground 2: Violation of the *Hardial Singh* principles

78 Mr Halim submitted that, by 22 March 2018, the Secretary of State had decided to make a deportation order in respect of GKG but had also decided not to certify his case under s. 82(1) of the Nationality, Immigration and Asylum Act 2002. By 5 April 2018, GKG had lodged an appeal, which meant that there was a long-term barrier to removal. At that point the Secretary of State had to consider not only how long it would take GKG to prosecute the appeal before the FTT, but also the timescale of any appeal to the UT (and potentially the Court of Appeal). In any event, on 19 April 2018, the Secretary of State's own authorising officer recognised that *'[n]ow that the subject has launched an appeal we are faced with a long-term barrier to removal'*. That was, Mr Halim submits, a recognition that detention was contrary to the third *Hardial Singh* principle and would be justified only for as long as necessary to effect a transfer to suitable accommodation in the community or to a secure mental hospital. Mr Halim submits that there never came a time when deportation was in prospect within a reasonable period; and that in any event, detention for as long as 16 months in the circumstances of this case was unreasonable and in breach of the second *Hardial Singh* principle.

Ground 3: Articles 3 and 8 ECHR

79 Mr Halim submitted that GKG was detained in breach of Articles 3 and 8 because he was denied treatment that was available, first in the community and then in a mental hospital; and this was due to failure on the part of the state and, in particular, of the Secretary of State.

The Secretary of State's submissions

Submissions of law

80 For the Secretary of State, Ms Thelen began with three propositions of law, which were agreed. First, she noted that, when assessing the health of a detainee, the Secretary of State is entitled to rely upon the opinion of clinicians or, if there is a disagreement, any one of them, provided that his or her view is sincerely and reasonably held: *ASK*, [220(iii)]. Second, even where application of the *Hardial Singh* principles would otherwise require release, continued detention may be justified pending transfer to a mental hospital: *ASK*, [231]. Third, when considering whether the Secretary of State has complied with her policy, it is necessary to focus on the action or inaction of her own officials; she cannot be fixed with responsibility for delays attributable to others, such as NHS personnel. This, Ms Thelen submits, is illustrated by the reasoning in *ASK* at [227].

81 Ms Thelen also draws attention to the judgment of Burnett J (as he then was) in *R (EO) v Secretary of State for the Home Department* [2013] EWHC 1236 (Admin). At [101], the Judge considered the Secretary of State's duties on receipt of an independent medico-legal report containing evidence that a detainee is a victim of torture:

> '101. Mr Brown submits that the receipt of an independent medical report should be considered as swiftly as a Rule 35 report, i.e. within two days after its arrival. Therefore, EO does not accept that the relevant date when his detention became unlawful was, as the Secretary of State accepts, 17 April. On this latter point, I accept that on the facts of this case Dr Toon's report should have been considered as part of the review process which culminated on 17 April 2012. Medico-legal reports of this nature require a good deal more time to digest than a Rule 35 report. As in this case, they are frequently accompanied by submissions of a wider scope and other evidence. Case workers cannot be expected to drop everything to prioritise this work to the possible detriment of other detainees. Like most public servants, they are under considerable pressure. I note that in *AM* the Court of Appeal considered that a fortnight to have considered the report from Miss Krajl, and conclude that it amounted to independent evidence of torture was appropriate. Such a time frame might well be reasonable when the monthly review is not imminent; but what is reasonable depends upon the circumstances.'

82 Ms Thelen also relies on the judgment of Maurice Kay LJ (with which Carnwath and Lloyd LJJ agreed) in *R (AR) v Secretary of State for the Home Department* [2011] EWCA Civ 857, [21]-[23]. She contends that it establishes that the Secretary of State is not obliged to anticipate potential challenges to removal.

83 The evidence, Ms Thelen submits, shows that the Secretary of State followed her policy correctly and lawfully. GKG was assessed promptly. From 27 February 2018, when he was classified at Level 3 for the purposes of the AAR Policy, the Secretary of State's officials began '*working towards release*'. Officials decided, properly and reasonably, that it would not be appropriate to release him to no fixed address. They worked diligently to identify accommodation. The application for Schedule 10 accommodation was made within days of receiving the rule 35 report. It was successful on the second attempt. Throughout this period, his detention was regularly reviewed. On each occasion, all relevant factors, including immigration factors and his Level 3 status under the AAR Policy, were taken into account.

84 Ms Thelen emphasises that GKG's presentation was variable. By July 2018, he had been assessed by Dr Hillier as no longer suitable for independent living. Thereafter, the Secretary of State followed Dr Hillier's advice in seeking a secure placement with a view to transfer under s. 48 of the MHA. But the Secretary of State cannot dictate clinical decisions or force a hospital to accept a patient whom it considers unsuitable. It was unfortunate that there was a long wait for a secure bed at the Bracton Centre and doubly unfortunate that, by the time one became available, GKG's condition had improved to the point where he no longer met the admission criteria, in the view of the clinical staff there.

85 Ms Thelen submits that it was reasonable, thereafter, to look for a secure placement in another hospital. After Dr Toogood advised that GKG did not meet the admission criteria for a place in a secure unit, it was reasonable to pursue the possibility of a place in a psychiatric intensive care unit. After Mr Dix's advice that that too was inappropriate, efforts were made to secure release into the community. Thereafter, identifying and arranging the necessary support from community and social care teams took time. Once concrete arrangements were in place, GKG was released.

86 The reasonableness of the steps taken at each stage meant, Ms Thelen submitted, that there was no breach of the AAR Policy. So far as the second and third *Hardial Singh* principles were concerned, it was necessary to consider the position as it appeared to the relevant decision-makers at each stage, rather than with hindsight. There was always a real prospect of removal within a reasonable period; and, given the diligence with which GKG's case was treated by the Secretary of State's officials, the overall duration of the detention – though considerable – was not unreasonable on the facts of the case.

87 So far as Articles 3 and 8 were concerned, Ms Thelen submitted that the evidence simply does not establish suffering of the kind that would meet the threshold required for a violation of Article 3. Nor was there a breach of Article 8, given that at each stage efforts were being made to secure that GKG was released into an environment where he could receive appropriate treatment.

Conclusions

The proper approach to Grounds 1 and 2

88 Before analysing the evidence in detail, it is necessary to say something about the proper approach to challenges alleging breach of policy and violation of the *Hardial Singh* principles in cases of this kind. I derive the following principles from the case law:

(a) The starting point for any challenge to detention is that, as Lord Atkin said in his dissent in *Liverside v Anderson* [1942] AC 206, at 245, '*every imprisonment is prima facie unlawful and that it is for the person directing imprisonment to justify his act*': see *Lumba*, [44] (Lord Dyson). This presumption is properly reflected in the AAR Policy.

(b) Immigration detention powers (such as those under regulation 32 of the EEA Regulations and paragraph 2(2) of Schedule 3 to the 1971 Act) may only be used for the purpose for which they were conferred, namely effecting removal or deportation. There are separate statutory powers, subject to separate safeguards, under the MHA to detain persons for medical treatment in their own interests. This means that immigration detention powers cannot, in general (and subject to (c) below), be used '*to protect a person from themselves*' in circumstances where removal within a reasonable time is no longer possible: *AA* at [40]; *ASK*, [229].

(c) As the AAR Policy makes clear on p. 4, '*the detention power can be exercised lawfully only if there is a realistic prospect of removal within a reasonable timeframe*'. The AAR Policy should therefore be read as relevant to the exercise of the detention power only where that precondition is met. If there is no realistic prospect of removal within a reasonable timeframe, the detainee will have to be released. The release does not, however, have to be immediate. As long as the detainee remains liable to removal, it is lawful for the Secretary of State to keep a person detained and safe for a reasonable time pending transfer to hospital: *ASK*, [231]. As a matter of principle, the same approach should apply where what is required before release is the provision of accommodation, with or without a support package, necessary to enable a detainee to live independently in the community. In determining what counts as reasonable, the scarcity of mental health treatment resources may be taken into account: see *ASK*, [2017] EWHC 196 (Admin), [191]-[192] (Green J) and [2019] EWCA Civ 1239 at [233] (Hickinbottom LJ). But if the Secretary of State breaches her duty to take reasonable steps within a reasonable time to effect transfer or to release with a suitable care package, the detention will become unlawful: *HA (Nigeria)*, [169]. What is reasonable will depend on a number of factors including the clarity and unanimity with which the detainee's needs have been identified and the degree of harm being suffered.

(d) Where there *is* a realistic prospect of removal within a reasonable time, the AAR Policy provides that a detainee assessed at Level 3 should be detained *'only'* if either *'removal has been set for a date in the immediate future, there are no barriers to removal, and escort and any other appropriate arrangements are (or will be) in place to ensure the safe management of the individual's return and the*

individual has not complied with voluntary or insured return' or *'the individual presents a significant public protection concern, or if they have been subject to a four-year plus custodial sentence, or there is a serious relevant national security issue or the individual presents the current public protection concern'.* It goes on, however, to emphasise the importance of deciding each case on its merits. This marches in step with the obligation to consider the effect of detention on a detainee's mental health when assessing the reasonableness of continued detention: *M* at [39].

(e) In some cases, the evidence will establish straightforwardly that a detainee's mental health would be improved if he were released, so that the decision whether to detain will turn on a simple balancing of immigration or public protection factors (which militate in favour of detention) against the effect of continued detention on the detainee's mental health (which militate against detention). In such cases, the AAR Policy provides a good guide for the type of cases in which detention is likely to be justifiable; and the use of the word *'only'* provides a strong indicator that detention is unlikely to be justifiable in other cases, absent some special factor.

(f) However, there will be other cases where the evidence suggests that the detainee's mental health would not be improved, and indeed may be adversely affected, by release. This may be the case where an individual would be street homeless if released or would be unable to cope in unsupported accommodation. In such cases, it will be necessary to consider the medical evidence very carefully. The evidence *may* show that a detainee's condition has deteriorated after initial detention, but would be likely to deteriorate further if he were released on to the streets or without an adequate support package in place. In those circumstances, it would be bizarre to read the AAR Policy, or the common law principles derived from *Hardial Singh* and subsequent cases, as imposing a duty to release in circumstances where that would be positively harmful to the detainee's mental health. But the duty to take reasonable steps within a reasonable time will still apply: see (c) above. If that duty is breached, the detention will become unlawful.

89 One important point not determined by the decided cases is how to assess the reasonableness of the steps taken by the Secretary of State to secure release where, as was the case for parts of the period of detention here, the identification and provision of accommodation under the Secretary of State's own powers (under Schedule 10 to the 2016 Act) is regarded as a precondition for the detainee's safe release. In assessing reasonableness, three matters should in my judgment be borne in mind:

(a) The power to provide accommodation under paragraph 9 of Schedule 10 applies only where the Secretary of State thinks that there are exceptional circumstances which justify the exercise of the power: see paragraph 9(3). Where a power is circumscribed in that way, it is obvious that a careful assessment will have to be undertaken before a decision is taken to exercise the power. Time must be allowed for this.

(b) Even where a detainee's circumstances are assessed as sufficiently exceptional to qualify for Schedule 10 accommodation, appropriate accommodation needs to be located, checked and secured. Not all Schedule 10 accommodation will be suitable

for every detainee. Liaison may be necessary with local care providers and others, such as the police. Again, time must be allowed for this.

(c) There is a limited stock of accommodation available and the Secretary of State cannot give priority to every case.

90 But, even bearing all of this in mind, where a medical need for release to suitable accommodation has been identified, and the provision of suitable accommodation is in principle within the Secretary of State's power, there must, in my judgment, be a special duty on the Secretary of State to ensure that there is no unnecessary delay in locating and securing appropriate accommodation: and the longer the detention continues, the more stringent must be the duty. Moreover, under the second *Hardial Singh* principle, there will come a time where the overall length of the detention ceases to be reasonable; and the fact that detention is having an adverse effect on a detainee's mental health will be relevant to the identification of that time.

The application of these principles to the facts of GKG's case

Preliminary

91 There is no dispute that GKG's detention was lawful at its inception on 20 February 2019. It is striking, however, that – as early as 27 February 2018 and throughout the next 16 months during which GKG was detained – the Secretary of State accepted, on the basis of unchallenged psychiatric evidence, that GKG was a Level 3 adult at risk under the AAR Policy. On 27 February 2018, the authorising officer reached the view that GKG could and should be released once Schedule 10 accommodation had been located. This triggered a duty to ensure that there was no unreasonable delay in locating and securing that accommodation. Later in the chronology, GKG's condition had deteriorated to the point where, in the view of Dr Hillier, transfer to a secure mental hospital was required. That triggered an obligation to ensure that the transfer took place within a time that was reasonable in all the circumstances. As the authorities make clear, what is reasonable is intensely fact-dependant. It is therefore necessary to break the period of GKG's detention into segments to see whether, at any stage, there was any unreasonable delay. I have concentrated in particular on the periods identified in Mr Halim's supplementary note, but have also made observations in respect of other periods.

28 February to 15 March 2018

92 Mr Halim notes that no explanation has been provided for the inaction between 28 February 2018 (when the case owner was searching for a possible release address and contacted the AARAT) and 8 March 2018 (when the AARAT was chased). Mr Halim submits that this was a particularly significant delay, since it contributed to the deterioration in GKG's mental health, as demonstrated by Dr Hillier's comments in the rule 35 report on 15 March 2018.

93 I do not consider the lack of evidence as to the precise steps taken between 27 February 2018 (when the AARAT were first contacted) and 8 March 2018 (when they were chased) justifies the inference that nothing was being done or that the delay between those dates was unreasonable. The GCID notes for 27 February 2018 indicate, even at this very early stage, a concern that '*Level 3 detention is difficult to maintain in detention*

for a prolonged period'. But there was also a lack of information about the risk that GKG would pose if released into the community. In my judgment, it was reasonable to seek fuller information on that question before deciding whether release into the community was appropriate.

15 to 22 March 2018

94 Once the rule 35 report was received on 15 March 2018, Mr Halim notes that it was not until 19 March 2018 that a request was made to the CCAT for Schedule 10 accommodation. This too was material, Mr Halim submits, given GKG's deteriorating mental health.

95 In my judgment, however, it would be unfair to criticise this delay as unreasonable. 15 March 2018 was a Thursday; 19 March 2018 was the following Monday. The AAR Policy provides (on pp. 21-22) that a rule 35 report is to be considered and responded to within 2 working days of receipt. I can see nothing inappropriate about that timescale. I do not think that it would realistic to criticise the Secretary of State's officials for making the request for Schedule 10 accommodation on the second working day after receipt of the rule 35 report.

96 Mr Halim was right to make no separate criticism of the delay from 19 to 22 March 2018, when the CCAT responded with the view that GKG was ineligible for Schedule 10 accommodation. It is sensible that there should be a separate team dealing with requests for Schedule 10 accommodation and understandable that it will need a few days to assess suitability when asked to do so.

23 March to 11 April 2018

97 Mr Halim asks three questions in respect of the period following the CCAT's assessment on 22 March 2018 that GKG did not meet the criteria for Schedule 10 accommodation. First, why was it not until 11 April 2018 (20 days later) that a second request was submitted to the CCAT for Schedule 10 accommodation? Second, why did it take six days from the teleconference on 5 April 2018 (at which it was confirmed that GKG did not meet the criteria for hospital admission) for the second request to the CCAT to be submitted? Third, why was no attempt made to pursue accommodation through organisations such as Shelter, once the CCAT had advised on 22 March? Mr Halim submits that the Secretary of State has provided no or no satisfactory answer to any of these questions.

98 In this respect, I consider that Mr Halim's submissions have force. GKG's detention was reviewed on 22 March 2018. The reviewing officer considered that the presumption of liberty was outweighed by the need to protect the public from GKG's offending, but also that *'[o]nce [Schedule 10 accommodation is] sourced, it is considered [GKG] should be released from detention*'. The authorising officer who countersigned the review knew that GKG had been detained for more than 3 weeks since his classification as a level 3 adult at risk. That officer was aware of Dr Hillier's prediction on 27 February 2018 that continued detention was '*likely to have a detrimental impact on [GKG's] mental health*' and his assessment in the rule 35 report just over 2 weeks later on 15 March 2018 that detention was, in fact, having such an impact. In those circumstances, the officer authorised detention '*whilst Schedule 10 accommodation is sourced and accepted*'

because '*GKG's medical requirements are best served with this course of action rather than releasing to no fixed abode*'. Yet, when on 22 March 2018 the CCAT assessed GKG as not meeting the criteria for Schedule 10 accommodation, it took until 12 April 2018 (a further 20 days) before a second request was made for Schedule 10 accommodation. There is no adequate explanation for this delay. There is no evidence that any officer of the Secretary of State's used that time to investigate the possibility of accommodation from Shelter or Mind (or elsewhere), though apparently GKG's solicitors did so, to no avail. In my judgment, it was not reasonable for the Secretary of State's officers to decide to detain GKG '*whilst Schedule 10 accommodation is sourced and accepted*' and then to take no concrete steps to secure that or any other accommodation (or otherwise to effect GKG's release) for 20 days between 22 March and 11 April 2018. It follows that GKG's detention during that period was not in accordance with the AAR Policy and was unlawful.

99 I should make clear that I have considered carefully Ms Thelen's submission that, on a fair reading of the detention reviews, this was a period during which detention was justified not only pending the identification of suitable Schedule 10 accommodation, but also for public protection reasons. There are, however, two difficulties with this submission. First, it does not accord with the reasons given by the authorising officer for authorising detention on 22 March 2018. Second, whilst there are circumstances in which a Level 3 adult at risk can be detained consistently with the policy, there is no evidence to indicate that anybody thought GKG's case fell within them. Public protection concerns were one reason why it was decided that GKG should not be released to '*no fixed abode*', but they were never advanced as a reason why he should remain in detention in an IRC notwithstanding the clear medical evidence of the adverse impact that would have, and was having, on his mental health.

12 April to 11 July 2018

100 During this period, the following steps were taken. There was a further Complex Case Healthcare Teleconference on 19 April 2018. Further medical evidence was submitted to the CCAT on 20 April 2018. CCAT agreed that GKG met the criteria and agreed to offer a self-contained address on 2 May 2018. On 9 May 2018, it advised that an address had been sought from an accommodation provider. Another accommodation provider was approached on 23 May 2018. Further information was sought on GKG's healthcare needs on 1 June 2018. Self-contained accommodation in Bradford was identified on 21 June 2018. The case owner was advised to contact relevant parties to obtain approval to discharge GKG to this address. The local police were chased twice by email and on 5 July 2018 advised that they had no objection. On 6 July 2018 GKG was informed of the grant of Schedule 10 accommodation. Yet, on the same day, the release submission was returned seeking further information. Mr Halim asks why, given the clear indications in the detention review on 31 May 2018 and at the Complex Case Healthcare teleconference on 14 June 2018, that GKG was suitable for release. The delay, he submits, meant that by the time the logistical arrangements were in place, GKG's mental state had deteriorated to the point where release was no longer possible.

101 Looking at the matter holistically, it took almost exactly 3 months, from the point when the second request for Schedule 10 accommodation was made on 11 April 2018, for that accommodation to be identified, checked and the arrangements made for GKG to be taken there. There was certainly activity during this period, but overall the period was in

my judgment too long. In particular, there is no adequate explanation of why it took the CCAT until 2 May 2018 to decide that GKG was eligible for Schedule 10 accommodation when the request had been submitted on 11 April 2018 and further medical evidence had been submitted on 20 April 2018. (The CCAT's initial decision that GKG was ineligible had been made within 3 days.) There is no evidence to indicate that the CCAT gave appropriate (or any) priority to GKG's case when assessing his eligibility or when seeking accommodation from their providers, as they should have done, given GKG's status as a Level 3 adult who was in principle entitled to release under the AAR Policy. Once accommodation was identified on 21 June 2018, there is no indication that the case-owner appreciated the urgency of the situation when liaising with the police. Chasing emails were sent on two occasions, but there is nothing to indicate that anything else was done (such as telephoning).

102 Given all these matters, it is necessary for me to reach a view about whether and if so when GKG would have been released if there had been no unreasonable delay. In my judgment, deducting periods of unnecessary delay, it should have been possible to assess GKG, identify appropriate Schedule 10 accommodation and liaise with local providers to make the necessary arrangements to transfer him there within a maximum of 6 weeks from 11 April 2018. It follows that, but for the unnecessary delay, GKG would have been released from detention on 23 May 2018. By that time, GKG had not yet deteriorated to the point where release into the community was impossible. This means that his detention from 24 May to 11 July 2018 was unlawful as contrary to the AAR Policy.

12 July to 6 November 2018

103 On 12 July, Dr Hillier expressed the view that GKG's condition had deteriorated so that he could no longer be safely released into the community and should instead be transferred to a secure mental health unit. From that point until it was decided that a secure placement was no longer indicated, detention was authorised pending transfer to a secure mental health unit. Mr Halim accepts, rightly in my view, that the delay in this period appears to be attributable not to any inaction by the Secretary of State, but rather to the unavailability of a bed at the Bracton Centre and then to the decision of the Bracton Centre that GKG did not meet their criteria for admission. Those authorising GKG's detention in this period voiced their concerns in increasingly trenchant terms about the length of time it was taking to locate a bed. They escalated the matter to the NHS commissioners. Mr Halim has not identified anything else they could have done to speed up the process. During this period, although there was a long delay, it was not attributable to the Secretary of State or his officials, who could reasonably conclude that it remained in GKG's interests that he continue to be detained in an IRC, where he would have access to medical support, rather than in the community. It was most unfortunate that GKG was detained for almost 4 months before the Bracton Centre finally assessed him as unsuitable for admission. But the detention during that period was not, in my judgment, unlawful.

104 I have not lost sight of Mr Halim's submission that, but for the unreasonable delays prior to 12 July 2018, GKG's mental health and behaviour would not have deteriorated to the point where transfer to a secure unit was required. I do not need to, and do not, make any finding about that. The evidence before me does not, in any event, enable me to do so. It is an issue that may be relevant to quantum, but for present purposes I am concerned with liability only, *i.e.* whether the Secretary of State acted lawfully when detaining GKG between 12 July and 6 November 2018. The answer to that question is 'Yes'. I have

reached that answer by reference to the facts before the Secretary of State at the time, not to a hypothetical state of affairs that might have obtained but for a previous breach of duty by the Secretary of State.

7 November 2018 to 20 January 2019

105 In this period, the Secretary of State was faced with a difficult situation. Dr Hillier and the team treating GKG remained of the view that he should not be released into the community, but only to secure accommodation. Until such accommodation could be found, Dr Hillier's view was that detention in the IRC was the '*next best alternative*'. The Secretary of State was, in my judgment, entitled to rely on this advice, notwithstanding that other clinicians at the Bracton Centre did not agree with it: see *ASK* at [220(iii)]. Mr Halim does not say that the Secretary of State should in this period have taken steps beyond those he did take, namely, arranging for GKG to be assessed by Dr Toogood and his team in Bristol and then by Mr Dix and the clinical team at Wotton Lawn Hospital. In my judgment, these steps were reasonable ones, there was no unnecessary delay and GKG's detention during this period was therefore lawful.

21 January to 26 June 2019

106 Before considering Mr Halim' specific criticisms of the action taken, or not taken, in this period, it is necessary to take stock of GKG's situation as at 25 January 2019. By this time, GKG had been detained for some 11 months, almost all of that after being identified as a Level 3 adult at risk. The first 4 ½ months of that detention had been spent trying to secure Schedule 10 accommodation. By the time that was found, his condition had deteriorated to the point where transfer to a secure unit was thought to be required. By the time a bed in a secure unit was found, nearly 4 months after that, those assessing him considered that his condition had improved so that it was no longer required. He was then detained for a further 2 ½ months while other secure placements were explored before, on 25 January 2019, Dr Hillier came round to the view that a community placement might be appropriate. It was then a further 5 months before GKG was in fact released, with a support package which Mr Halim described, aptly in my view, as minimal (in the sense that it involved precisely the same access to a GP and to the local mental health crisis team that would be available to any patient in the community with mental health problems).

107 Judges considering claims for unlawful detention must be careful not to apply hindsight, but rather to look at each individual period of detention and to assess, on the basis of the information before the Secretary of State at the relevant time, whether the detention was lawful. But part of the information before the Secretary of State at any given time is how long the individual has already spent in detention and in what circumstances. In considering this last period of detention in particular, it may be fairly noted that GKG's case does not appear to have been accorded the urgency or priority that its long and unfortunate history justified.

108 Mr Halim makes a number of specific criticisms which have force, especially when seen, as they should be, against the background I have described. First, Mr Halim submits that, by 21 January 2019, the position was clear. Three independent assessments had concluded that GKG did not now meet the criteria for admission to a secure unit. By 25 January 2019, Dr Hillier had come round to this view ('*It would seem that a community*

placement option is going to be the next way forward'). On the same date, the authorising officer authorised detention for a further 28 days but said: '*I am prepared to authorise 28 days more detention, but during that period release to Schedule 10 accommodation or a secure NHS facility must occur (assuming removal doesn't*)' (emphasis added). Despite this, in the detention review on 22 February 2019, the director expressed doubts about whether releasing GKG into the community was right. I accept Mr Halim's submission that it is difficult to see why further advice was required at this stage. There were three independent reports – from the Bracton Centre, Dr Toogood and his team and Mr Dix and the team at Wotton Lawn Hospital – saying that release to the community was appropriate. Dr Hillier had indicated that a community placement was likely to be the way forward. If further advice was to be sought from Dr Hillier, there was an onus on the Secretary of State's officials to seek it immediately after the detention review on 25 January 2019 and certainly well before the expiry of the 28 days' detention authorised on 25 January 2019. The lack of urgency with which GKG's case was being treated is exemplified by the fact that the first email to probation, with respect to the MAPPA arrangements in force for GKG (and to enquire as to the date of the next meeting), was sent on 21 February 2019, nearly a month after Dr Hillier indicated that a community placement would be the next option. The authorising officer's comments on the detention review on 22 February 2019 contain no reflection of the fact that the previous authorising officer's stipulation that release to Schedule 10 accommodation or a secure NHS facility *'must'* take place within 28 days.

109 Second, Mr Halim says that, by 19 March 2019, Dr Hillier had agreed that a release to Schedule 10 accommodation was most likely indicated. This was reiterated at the MAPPA meeting on 25 April 2019, the minutes of which were received on 3 May 2019. Mr Halim submits that no proper justification has been advanced for not advancing GKG's release in the face of this consistent advice. I accept that the Secretary of State was in this period anxious to check that the support GKG would need would be available in the community and anxious also to obtain the agreement of relevant partners at MAPPA meetings and of GCC with the care package proposed. But it was the Secretary of State who assumed the role of co-ordinating with the various third parties whose co-operation was desirable in the interests of safe release and there is no indication that this role was discharged with appropriate urgency, given the length of time for which GKG had already been detained. What in fact happened is that the GCC and the other MAPPA partners were allowed to dictate the timetable. Their schedules were treated as external determinants about which the Secretary of State could do nothing. For example, after the initial MAPPA conference on 14 March 2019, 6 weeks elapsed until the next MAPPA meeting (at which it was agreed that GKG would be offered '*the same universal provision as anyone else with autism*'). Given the length of time for which GKG had already been detained, it was incumbent on the Secretary of State to do more to speed up the process. An officer of appropriate seniority should personally have taken charge of GKG's case, emphasising to all relevant third parties the urgency of agreeing on the necessary care package and setting timetables by which it would be necessary to release GKG.

110 Third, Mr Halim notes that the release plan agreed on 30 May 2019 was precisely the same as that implemented on 26 June 2019. There is, he submits, no proper justification for this delay. This criticism has force. I would add that GCC's approval of the (minimal) care plan that was in due course put in place was communicated on 30 May 2019. At that time, it was said that a 1 to 2 week time frame would be optimal to ensure GKG was

informed of the discharge and transition plan. Yet despite this, and despite the known history of the case, a release submission was again rejected on 4 June 2019; and GKG was not in fact informed of his release until 21 June 2019. (That he was not released on that day is understandable given that that was a Friday and in light of the need, which had already been identified, to ensure that GKG was released during the week, when crisis support would be more readily available should it be needed.)

111 Overall, I find that, had the case been treated with the urgency it required, GKG could have been released within 6 weeks of 25 January 2019, i.e. by 8 March. Given that by this time GKG had been detained for more than 12 months since being identified as a Level 3 adult at risk, and in the circumstances I have described, detention after this date also breached the second *Hardial Singh* principle. This means that his detention from 9 March 2019 to 26 June 2019 was contrary to the AAR Policy, unreasonable and unlawful.

112 It will be apparent that, on my findings, the detention in this case fluctuated between periods of lawful detention and periods when the detention was unlawful. One of the periods of unlawful detention (23 March to 11 April 2018) spanned the date (5 April 2019) on which GKG lodged his appeal against the decision to make a deportation order. Prior to that date, the Secretary of State could properly consider that he would be able to deport GKG within a reasonable period. But even so, the AAR Policy, read in accordance with the principles I have identified, imposed a duty on the Secretary of State to take reasonable steps to secure his release within a reasonable period. Given that on my findings that duty was breached, the detention was unlawful. There is force in Mr Halim's submission that, from 19 April 2018, the Secretary of State accepted that the appeal gave rise to a long-term barrier to removal. The detention review of that date constituted a recognition that the third *Hardial Singh* principle was no longer met. The comments made by the officers who authorised detention thereafter for the most part show that they considered detention from that point to be justified only pending transfer to Schedule 10 accommodation or to a secure hospital. In those circumstances, the key question was whether, in detaining GKG, the Secretary of State complied with his duty to take all reasonable steps to procure GKG's transfer (either to Schedule 10 accommodation or to a hospital) within a reasonable time. The question of whether detention might have become unlawful under the third *Hardial Singh* principle even if GKG did not have ASD does not, accordingly arise; and I do not decide that issue.

Articles 3 and 8 ECHR

113 I can deal with this aspect of the case relatively quickly, in light of the fact that Mr Halim addressed it only very briefly in oral submissions. In my judgment, a review of the medical evidence does not justify a finding of violation of Article 3 ECHR. That is so for three reasons.

114 First, for the first part of his detention (up to 12 July 2018), GKG was detained pending transfer to Schedule 10 accommodation. During this period, GKG's cannot be said to have been a case of denial of treatment that would otherwise be available. The reason why it was considered necessary to release him was not that release was a precondition for treatment but that there was no treatment that could ameliorate his symptoms other than a change of environment. Although there is evidence that his condition deteriorated over this period (as Dr Hillier had predicted at the outset), so as retrospectively to justify his classification as a Level 3 adult at risk, the medical evidence does not establish to the

relevant standard (i.e. conclusively) the level of suffering necessary to engage Article 3. It is relevant for these purposes that GKG was throughout monitored conscientiously by Dr Hillier, a specialist, and his team.

115 Secondly, while held pending transfer to a secure mental hospital (from 12 July 2018), as I have said, there was no breach of the Secretary of State's duty to take reasonable steps to secure transfer within a reasonable time. Whilst I accept that Article 3 ECHR may in some circumstances impose a duty on the state to take positive steps to ensure that an individual is not subject to inhuman or degrading treatment, the nature of the positive steps must take proper account of the limited resources for mental health treatment. The circumstances of the present case are not so extreme as to give rise to a breach of the Article 3 positive duty. Even if they were, I must bear in mind that this claim is brought against the Secretary of State for the Home Department, not against the state as a whole.

116 Thirdly, once Dr Hillier came round to the view that a community placement would be the next appropriate option (on 25 January 2019), the medical evidence does not establish (whether to the requisite standard or at all) suffering of the kind that would give rise to a violation of Article 3.

117 I accept that the focus of Article 8 is different from that of Article 3. I also accept that it is wrong reflexively to plead Article 8 in the alternative in a case where the suffering alleged does not, or may not, reach the minimum level of severity required by Article 3. But knowingly to detain a person suffering from ASD in circumstances where there is medical evidence that detention is likely to lead to a risk of harm is, in my view, to interfere with his psychological integrity in a way which engages Article 8 ECHR. Whether the detention is justified under Article 8(2) will depend on the reasons for it. Where the relevant decision-maker purports to justify detention as necessary pending transfer to Schedule 10 accommodation or pending transfer to a mental hospital, the justification will depend on whether the Secretary of State has complied with her duty to take reasonable steps to effect transfer within a reasonable time (i.e. the same test as I have held applies to determine whether detention is lawful).

118 It follows that, for the periods during which I have held GKG's detention was unlawful because it was in breach of the AAR Policy and/or unreasonable, it was also in breach of GKG's Article 8 rights. I doubt that the breach of Article 8 will add much, if anything, to the damages to which GKG is in any event entitled for unlawful detention, but I do not need to decide that now.

Result

119 For the reasons set out above, I have concluded that GKG was detained unlawfully and in violation of Article 8 ECHR:

(a) from 23 March to 11 April 2018;

(b) from 24 May to 12 July 2018; and

(c) from 9 March 2019 to 26 June 2019.

120 I do not consider that it would be appropriate to assess damages at this stage. Further evidence may well be required. I will invite submissions from Counsel as to the directions that should now be given in the light of my findings.