CO/14783/2013

Neutral Citation Number: [2013] EWHC 3764 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
THE ADMINISTRATIVE COURT

Royal Courts of Justice
Strand
London WC2A 2LL

Tuesday, 19 November 2013

B e f o r e:

MR JUSTICE OUSELEY

Between:
THE QUEEN ON THE APPLICATION OF MUAZA

Claimant

v

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Defendant

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(Official Shorthand Writers to the Court)

Ms E Laing, QC and Nicola Braganza (instructed by Deighton Pierce Glynn) appeared on behalf of the **Claimant**
Mr M Gullick (instructed by Treasury Solicitor) appeared on behalf of the **Defendant**, Ms E Grey, QC at Judgment

J U D G M E N T
(As Approved by the Court)

1. MR JUSTICE OUSELEY: These two cases raise common issues over the lawfulness of the exercise by the Secretary of State for the Home Department of her powers of detention in respect of immigration detainees whose refusal to take food and fluids causes them life threatening physical conditions, and over whether there comes a stage at which such a detainee's continued detention after the refusal to take food or fluids involves a breach of rights under Articles 2 and 3 of the European Convention on Human Rights.

2. Mr Muaza's case is a rolled-up hearing. He remains in immigration detention. Interim relief in the form of a release was refused on 17 October 2013 by Stuart J in a reserved judgment [2013] EWHC 317 Admin, and by Collins J on 28 October 2013. Sid Ahmed Adda's case is a permission hearing only. He was released from immigration detention on 17 October 2013 not because of his hunger strike but because, says the Secretary of State, there was no sufficiently imminent prospect of his removal to Algeria.

3. The facts in Mr Muaza's case are important. He is a Nigerian national aged 45 who became an over-stayer on 23 January 2008 following the expiry of a 6-month visitor's visa on which he had entered. He applied unsuccessfully for leave to remain under Article 8 ECHR in May 2011. He was taken into immigration detention on 25 July 2013. He then made an asylum claim which was rejected and certified as manifestly unfounded on 7 August 2013. He said he had come to the UK for a better life. On 25 August 2013, Mr Muaza began to refuse food and has continued to do so since, save for a brief interruption in mid-October and a few other isolated occasions.

4. Although he had stopped taking food on 25 August, he continued taking fluids on those days. He remained on green in the black, red, amber, green code, BRAG, for those risking becoming unfit for detention. This code applies to those who refuse food and fluid. "Green" is described in the Home Office document as:

> "Distant, threat of becoming unfit for detention materialising includes those on food/fluid refusal that are not yet causing concern and are compliant with having their observations taken".

"Amber" means that the risk of becoming unfit for detention is approaching. "Red" means that the threat is close. "Black" means:

> "Imminent immediate risk of becoming unfit for detention or currently unfit for detention, includes anyone causing concern and therefore admitted to health care, their observations may still be noted as normal as the results are within normal range. However, they are in black as their observations are lower than their ones taken upon arrival. This will include all those already declared unfit for detention but also those for whom the observations and medical assistance indicate a strong likelihood of death or serious permanent damage to health."

5. Mr Muaza moved to amber briefly on 12 September. He has at times claimed that the food was spicy and did not suit various medical conditions he had. But he could and

sometimes did eat cornflakes and other food. He declined to go to the dining hall because he said he had a special diet. He reverted to green.

6. On 24 September 2013 he stopped taking fluids save, intermittently, thereafter. On 29 September he moved to black from green the previous day and has remained on black since. During September he had refused only one medical observation and had said on the 19th that he would accept referral to hospital if need be. On 30 September he refused to take the "Ensure" drink prescribed for him because of the sugar which he thought was a serious problem for him and he said that he was unable to tolerate food.

7. On 4 and 6 October he received a telephone and then face-to-face assessment from Dr Hartree of Medical Justice. Her report of 10 October concluded that his detention and mental and physical ill-health were interrelated and that his mental health would not improve without a form of psychiatric treatment. She did not consider that it was likely he was protesting against detention in a calculated way, but that his dislike of detention had become expressed in delusions which were now fixed. He had the capacity to make simple decisions relating to his immigration status but not about food intake since he thought that any food given to him in the Immigration Removal Centre, IRC, was bad for him.

8. On 6 and 7 October he refused to go to hospital, although during the hearing before Stuart J on 16 October, he did go to hospital briefly where he received some re-hydration and had briefly resumed eating. He told the doctor at Hillingdon Hospital that the food at the IRC was not suitable for a kidney condition he had and that it caused rectal bleeding.

9. After the refusal of interim relief by Stuart J, Mr Muaza resumed his refusal to take food and fluids on 19 October. On about 23 October he had said, during the course of an ACDT review, Assessment Care in Detention and Treatment, as follows:

> "He no longer wishes for any further help. He has asked for to sign the 'advanced directive'. He has been given the paperwork but has so far not signed it."

In fact on the same day he did complete an advanced directive or decision, an earlier one having only been partially completed on 18 September. The advanced decision, or directive, which he did complete, says this:

> "1. Don't want to eat. [I do not intend to eat].
>
> 2. I do intend to drink or otherwise receive fluids. [Doesn't want to drink or take any fluids].
>
> 3. I do not wish to receive any medical treatment. [Doesn't want to have any medical treatment].
>
> 4. I do not consent to the administration of nutrition or hydration or any form of medical treatment whether resuscitation or otherwise designed to keep me alive in the event that there is a

deterioration in my condition."

10. Paragraph 5 of the form as he has signed it says that he does not consent to medical or nursing care designed to keep him comfortable or free from pain in the event of serious deterioration of his condition. Paragraph 6 acknowledges that it has been explained to him that if he refuses treatment in this manner that his medical condition could deteriorate, that he could be in a great deal of pain, could lose consciousness and could die as a result of the refusal to consent to treatment. He has written "yes" under that paragraph. He then has written "yes" against paragraph 7, which says:

> "I have read and had the contents of this directive read over to me [in a language he understands and he fully understands its contents and effect]."

Paragraph 8 says:

> "He has been advised to take legal advice from an independent legal adviser on the contents and effect of this advanced decision. He has carefully reflected on the terms of it and has been advised to discuss its terms with his next of kin before signing. [He acknowledges that that is so by signing 'Yes']."

He says then that he is aware that he can change his mind and revoke this advanced decision at any time if he remains capable of making decisions about his medical treatment. That is marked "yes" and the form is then signed by him --

11. That decision has not been revoked. The medical records make clear that observations were refused by Mr Muaza on 24 and 25 October. There appear to have been some observations on 26 October, although the IRC staff may not have had access to his health care medical records. On 26 October, after Stuart J had refused interim relief and two days before Collins J again refused interim relief, {}Dr Raja, a doctor based at the IRC, filled in part C of form IS91RA in which he said this:

> -"Mr Muaza is refusing food and fluids, now on constant watch. He is refusing observation, dehydrated ++. His last blood sugar level was 2.9 on 22/10/13. Prior to that 2.8mm/l. Since then his condition cannot be assessed as refused observations. Clinically difficult to assess his health condition. His BP on 22/10 106/66. In view of his general health condition today he is not fit for detention at Harmondsworth Centre to meet his medical needs."

This was the first time during his detention that Mr Muaza had been assessed as unfit for detention in the IRC. It is, however, clear from its terms that the Doctor was not saying that he was unfit for detention in any place in which he might lawfully be detained, but was relating it to the IRC in which he was detained and which might, of course, stand for unfitness for detention in any IRC. It did not contemplate whether Mr Muaza was fit for transfer to a prison hospital or to an outside hospital, but nonetheless in detention.

12. The response of the authorities at the IRC to this part C on 28 October was as follows:

> "Mr Muaza is currently under FFR log and is challenging the legality of his detention at the High Court. He was seen by the resident psychiatric (Dr Burren) on 24/10/2013 at 20.10 hours. Dr Burren recorded Mr Muaza's complaint that he was not being provided appropriate food and that his asylum process was taking too long which led to his decision to refuse food and fluid. However, Dr Burren assessed Mr Muaza to show no sign of psychosis and assessed him to have no mental disorder.
>
> On 26/10/2013 Mr Muaza was again seen by Mr Raj, however Mr Muaza refused to be assessed and due to this his condition cannot be assessed, and as a consequence they have stated he is not fit for detention at the IRC, as the IRC is unable to fulfil his medical needs.
>
> Whilst it appears that the Doctor has concluded he is unfit for detention the opinion is not based on clinical assessment as Mr Muaza has refused to be assessed or have his observations taken. Given his immigration history, continued detention is appropriate at least while his judicial review application is being considered."

13. This was not a decision that clarification should be sought of the basis for the view expressed by Dr Raj, since Dr Raj's opinion said that it was not based on clinical observations but a view of general health conditions. Nor was it a decision that a second medical opinion should be sought, nor was it a decision that very exceptional circumstances applied. The significance of that will appear when I deal with the policies. Nonetheless, detention was maintained on the basis that the opinion was not based on clinical observation.

14. After 26 October, Mr Muaza was generally assessed as unfit for detention, sometimes with the qualification that he was unfit because the Doctor had been unable to examine him and so could not state that he was fit for detention. On 27 October he declined observations and all medical interventions. He was, however, examined by a Doctor instructed by his solicitors, Dr Beet, who recommended urgent hospital admission for investigation and treatment for an urgent and life threatening condition. Nothing was said there about treatment outside of detention or the significance of a refusal of hospitalisation.

15. On 28 October the claimant refused an examination and refused hospitalisation. This happened again on 29, 30 and 31 October although it appears that some observations were taken over that period. Nonetheless this was a persistent refusal of hospitalisation for the treatment his own Doctor had recommended.

16. On 1 November 2013 he was assessed by Dr Khan, the psychiatrist for the defendant. Dr Khan concluded as follows:

> "1. In my opinion Mr Muaza does not suffer from any severe and enduring mental illness including schizophrenia,

schizo-affective disorder, bipolar affective disorder, or major depressive disorder.

2. His current presentation is more suggestive of adjustment disorder with low mood, pain and anxiety, with a background of stressful circumstances, such as detention and pending deportation. I endorse the finding of Dr Burren's opinion of situational stress.

3. I believe that Mr Muaza does not require any psychotropic medications in the absence [of a] diagnosable mental illness.

4. Mr Muaza can benefit by CBT (cognitive behaviour therapy) and anxiety management.

5. If Mr Muaza's nutritional status improved he would be fit for detention and subsequently fit to fly."

17. Earlier in the examination Dr Khan answered questions posed concerning capacity. He said that Mr Muaza has been aware of the consequences of refusing food and fluids, namely organ failure and possibly death. Dr Khan believed he did understand, retained the information, and weighed up the decision about refusing food and fluid. He said, "I believe that he has full capacity". He then said that Mr Muaza was aware of the increasing risk of deterioration in his physical health but, "he has full capacity to refuse medical treatment". He added that mental illness and general deterioration and mental capacity brought about by the consequences of refusing food and fluid did not necessarily mean that a person lacked capacity and that making a decision that seemed to others irrational did not in itself indicate lack of capacity. He was not detained under the 1983 Mental Health Act.

18. It is specifically not contended before me that Mr Muaza lacked then or lacked now the capacity to decide whether to refuse food or fluid or that he is unaware of the consequences of such a refusal or that he lacks capacity to decide to refuse medical treatment unless it is on the terms that he sets out, that is to say, release from detention. That is the position as it was before Stuart J.

19. After 1 November, observations continued to be refused on most days, although sometimes he did permit some observations or observations were made of a sort which could be done without the need for his co-operation. Nonetheless, that meant in the minds of the doctors, that the clinical risks to him were increasing and that is what underlay the continued unfitness for detention assessment, save for perhaps 3 November when Dr Raj said that he was fit for detention although that was clarified the next day. Mr Muaza refused hospitalisation on 1 November, 4 and 5 November, declaring that he wanted to die. On 5 and 7 November he was still assessed as fit to fly.

20. On 7 November Mr Schaapveld, a psychologist instructed on behalf of Mr Muaza, examined him, but concluded not that he should be released, but that he should go for in-patient assessment in a psychiatric facility as he appeared to be suffering from a

form of psychotic disorder in which auditory hallucinations affected his taking food. Mr Schaapveld is not, unlike Dr Khan, a psychiatrist.

21. On 8 November the Doctor said that there had been significant changes in physical health. Another part C was completed on behalf of a GP, Dr Mann. This said:

> "Mr Muaza is reported to have been refusing diet and fluids for 20 days. He is currently in level 3 care due to concern re: his condition, he is refusing diet and fluid in protest at his detention, he has been deemed to have mental capacity by a medical team, he has already been deemed unfit for detention as his needs cannot be met at IRC Harmondsworth.
>
> We have been able to test the urine specimen this afternoon which provides us with some updated information.
>
> Mr Muaza agrees to observations periodically but has declined to provide a venous blood sample for testing. His most recent set of observations are OUTSIDE of normal range, body temperature. Body temp, 35.1, blood glucose estimation 2.6mmol, blood pressure 82/58, his pulse is the only measure within normal range which is fluctuating between mid70s to 80s. He has lost 4kgs since admission to health care.
>
> His urine specimen tested positive for blood and generated a high specific gravity reading. This would be indicative of dehydration and consistent with his food refusal. We will continue to monitor as Mr M allows us to, but as we have managed to capture some objective measures from him today we wanted to update you using the part C."

22. Mr Gullick for the Secretary of State says that this was the first unfitness for detention opinion based on observations. The health care review said that he was still refusing all observations but was very weak. Again, that assessment was that he was unfit for detention in Harmondsworth IRC. On that same days, 8 November, Mr Muaza again refused the offer of hospitalisation. On 9 November Dr Raja another part C, said:

> "Mr Muaza's condition remains the same. He is refusing his observations. Latest BM2.6, BPH2/58 urine blood +++. Tongue hydrated. His medical condition is not fully assessed as he is refusing all observation today. He is unfit for detention to meet his medical needs at Harmondsworth detention centre."

There is also this comment from Healthcare review on 9 November:

> "Detainee has health needs which cannot be met within an IRC. He is spitting blood. Seen by GP. Declined vital signs of bloods. Seen taking sips of water."

23. Continued detention was recommended on form 93F dated 11 November on the same basis as it had been after the first part C on 26 October, namely that there were insufficient observations and that he had refused to be observed. Oddly, it was said on

10 November that was fit for detention on that day. On 9 November, Mr Muaza was again seen by Dr Hartree who reported on the 12th. She concluded that to recover from his starvation, Mr Muaza would probably be unable simply to start eating or drinking in any significant amount but would require hospital treatment with intravenous fluid and thiamine followed by slow-graduated re-feeding with close clinical monitoring for the complications of re-feeding syndrome. The timescale of survival was not possible to predict accurately, but he was dangerously malnourished, weak and dehydrated. He could collapse at any time or could last a few days or weeks longer. He had signs of thiamine deficiency which was usually the life-limiting factor in starvation. If he continued to be unable to drink, his circulation could collapse from dehydration. He was at a late stage of starvation getting closer to organ failure and to life-threatening complications. The report did not suggest that he would be unfit for detention in hospital for treatment were he to consent to go there. There was no suggestion that there was any difference between what would be provided in hospital and what would be provided in the IRC to someone refusing treatment.

24. On 12 November the claimant was unresponsive to questions in an interview in the ward at the IRC with the Nigerian High Commission, although earlier that day, according to the detention record, he had been able to meet his legal team and to get out of bed with no difficulty. On that same day he again refused hospitalisation. The most recent part C by Dr Raj on 14 November sets out what is necessary for an end of life plan for Mr Muaza, but in its summary, repeats that Mr Muaza states that he would rather die than be deported, that he is at risk of further physical and mental deterioration resulting in irreversible organ damage or death. Mr Muaza presented with a risk of re-feeding syndrome which would require great care in the re-introduction of food and fluids. But it also confirmed that Mr Muaza "declined to transfer to hospital, this is against medical advice". Part C continues:

> "Mr Muaza has been assessed by our in-house medical team as having mental capacity in accordance with the Mental Capacity Act. He has made a verbal advanced decision that he does not wish to receive treatment should his health decline to the point that emergency/life saving treatment is required. This is recorded in his medical notes. Mr Muaza states he understands the risks associated with his advanced decision and accepts that this will eventually lead to his death. It has also been explained that the validity of any advanced decision can be questioned by the health team if the circumstances in which the advanced directive may change."

25. The end of life plan is a careful plan which includes many steps for Mr Muaza's comfort from the nursing staff, psychological support, appointments with the welfare team and appointments with his legal team to ensure that his wishes are understood and that he is aware that he can revisit his advanced decision at any time. But there remains no doubt but that he would only be willing to receive treatment if it were on the terms that meant his release from immigration detention.

26. The claimant's case is that detention became unlawful either as a matter of statutory power or, in the terms of the Secretary of State's policies, either on 26 October after the

first part C from Dr Raj was completed or at the latest after 8 November when the defendant accepts, notwithstanding what the IRC then said, that there was an observation-based report of unfitness for detention in the IRC.

27. I turn then to those submissions. The first submission in relation to lawfulness, one newly developed as from the Friday before the hearing before me, was that the Secretary of State had no power to detain an immigration detainee in an ordinary non-mental hospital. The significance that of is this. If the claimant needed treatment in the hospital which the IRC could not provide he would have to be released from immigration detention in order for him to receive it. That is precisely the position Mr Muaza wanted to be in because, for him, it carried with it an assumption that he would then remain at large on conditions of temporary admission or possibly on bail.

28. Ms Laing QC, counsel for the claimant, asserts that under a combination of interpretations of the law and statute and policy, the Secretary of State has no power to take the claimant to hospital, for example Hillingdon NHS Hospital, for treatment necessary for a physical condition arising out of prolonged refusal for food and fluid, to keep him in detention in hospital, and to return him immediately upon discharge from hospital to the detention centre. The claimant is not prepared to consent to treatment in the hospital while in detention but would be willing to receive precisely the same treatment as an in-patient in the same non-prison hospital if not there in detention, and able to enjoy thereafter discharge to some non-custodial address even though perhaps with reporting or even tagging requirements and sureties.

29. Both Mr Muaza and the other claimant, Mr Adda, face administrative removal by direction under section 10 of the Immigration and Asylum Act 1999 to which schedule 2 of the 1971 Immigration Act applies. Section 4(2)d of the 1971 Act provides that detention pending removal is governed by schedule 2, paragraph 16(2) of which provides for the liability to detention of people pending removal. Paragraph 18(1) provides in broad terms:

> "Persons may be detained under paragraph 16 above in such places as the Secretary of State may direct..."

There is no limit there on the places in which a person may be directed to be detained pending administrative removal pursuant to removal directions. The directions themselves are contained in the Immigration (Places of Detention Direction 2011) made under paragraph 18(1) of schedule 2 to the 1971 Act. The places listed in the direction include places at port, and, "(c) any short-term holding facility, including police stations, appeal hearing centres, named IRCs", and, "(d) any hospital", and "(e) any prison or Young Offender Institution."

30. "Hospital" is defined in the Direction. It has, in England and Wales, "the same meaning as in the Mental Health Act 1983". "Hospitals" in section 145 of the 1983 Act is defined this way:

> '"Hospital' means.

(a) any health service hospital within the meaning of the National Health Service Act 2006 or the National Health Service (Wales Act) 2006, and.

(b) any accommodation provided by a local authority and used as a hospital by or on behalf of the Secretary of State under that Act, and.

(c) any hospital as defined by section 206 of the National Health Service Wales Act 2006 and the definition which is vested in a local health report."

On its face that definition is amply wide enough to cover any hospital whether or not a mental hospital, and whether or not a person is compulsorily detained in a hospital where people may be compulsorily detained under sections 47 or 48 of the 1983 Mental Health Act. Ms Laing QC for the claimant points out that the defendant could have, but did not move directly, to use in the Direction the definition of "hospital" in the National Health Service Act 2006, section 275, and so significance ought to be attributed to the incorporation of the Mental Health Act definition. It was there, she submitted, to allow for the fact that someone could be detained pursuant to sections 47 and 48, the latter applying in the case of someone in immigration detention if suffering from a mental disorder of a nature or degree which made it appropriate for him to be detained in a hospital for medical treatment. These detention powers should be construed narrowly and not so as to include detention in a hospital for treatment for physical ailments, or for a mental illness which did not meet the requirements for compulsory detention under the Mental Health Act.

31. She also referred me to the provisions of the Prisons Act 1952 to illustrate how powers which were intended to be as wide as the Secretary of State contended she possessed in relation to immigration detention were expressly set out in relation to prisons. This was said to support the inference that her immigration detention powers were not intended to be so wide, in the absence of an express provision covering them in relation to immigration detention, and the difference between the two sets of powers was deliberate. By section 12 of the Prisons Act, a prisoner could lawfully be confined in any prison. By section 22, express provision was made for his transfer in detention to a hospital for medical treatment. He was to be kept in custody there and in transit unless the Secretary of State directed otherwise. No such provision, save for section 48 of the Mental Health Act 1983, was made for immigration detainees. Section 156 of the Immigration and Asylum Act 1999 made provision for transfer but only between places where the detainee could lawfully be detained and schedule 12, via section 155, provided for compulsory medical examination for diseases which could effect the health of others but for no more than that.

32. The effect of all that, according to Ms Laing, with the relevant Secretary of State policy, is not to mean that those immigration detainees must however only receive whatever treatment can be provided in the IRCs or prison where they may be detained in immigration detention. The effect, on her submission, is that the Secretary of State's policy in detention requires her to release from detention and prison or removal centre

those who need treatment in a hospital beyond that which can be provided by the removal centre or prison or in detention under the 1983 Act in order that they can, if they wish to have treatment in the hospital to meet their conditions, go to hospital on temporary admission.

33. If there is no power in the Direction to detain immigration detainees in hospital save under the compulsory provisions of the Mental Health Act 1983 and, if they require treatment for a serious medical condition which cannot be obtained in the IRC or in prison, the effect of the Secretary of State's policy is that they must be released rather than forego necessary treatment for serious medical conditions save in very special circumstances.

34. However, I do not accept the contention that the defendant's power is so limited. Indeed, I do not regard the limitation argued for as arguably present. Thus, the language of schedule 2 to the Immigration Act does not contain the limitation suggested on the places in respect of which a Direction can be made. The Direction itself does not contain any express limitation of the sort contended for. "Hospitals" in the definition in the Direction appears to be wider than in the National Health Service Act 2006 alone, and that may be the reason for that choice of definition. But it at least expressly includes all those hospitals which are covered by the National Health Service Act 2006 definition. There is no obvious or necessary reason to restrict the scope of hospitals within that definition to those mental hospitals in which patients may be compulsorily detained, since that is neither expressed, nor a necessary implication of the use of the Mental Health Act definition. That definition covers a wide range of hospitals and includes many where no patient would be compulsorily detained. Had so restricted a power been intended, it is that restriction which would have been expressed rather than being left as an inference to cut down the deliberately wide language used. It was not just a rather over-wide way of catering for section 48 of the Mental Health Act 1983, if that was indeed necessary at all. The existence of the power of compulsory detention under that Act cannot warrant the inference that it was the sole basis for that choice of definition of hospital in the direction.

35. As Mr Gullick for the defendant pointed out, Ms Laing's contention would create a remarkable and pointless gap in the defendant's powers of detention. Once an immigration detainee could not receive medical treatment necessary for illness or injury in the detention centre or prison he would have to be released, whether or not waiting administrative removal, or deportation, and however serious a risk of absconding or re-offending he presented, unless very exceptional circumstances applied. Those very exceptional circumstances would have to provide the justification for preventing an individual receiving the necessary hospital treatment, for want of a power to maintain his detention in the hospital where he needed to go for treatment and regardless of his willingness to go there in detention. Whether viewed from the perspective of the defendant or of an immigration detainee the gap would be serious. It is not easy to see that it would be much of an answer to an Article 2 or 3 ECHR challenge to say that the reason there was no hospital treatment was that there was no power to take him to hospital in custody and he was too dangerous to be released.

36. While I accept of course that general statutory powers of imprisonment should be strictly construed, and there is certainly no presumption in favour of detention, see R(on the application of Lumba) v Secretary of State for the Home Department [2011] UK SC12 [2012] 1 AC 245 para.53 (Lord Dyson), in my judgment, the power to detain in a non-mental hospital for physical treatment or for treatment other than under section 48 of the 1983 Act is plainly confirmed.

37. I did not find the Prison Act advanced understanding of the differences between the immigration and detention regime. Rather, the two statutory powers contain the same sort of provisions, but differently expressed. I think that the consequence of the differences arises simply because it was not necessary to spell out the power to take someone in immigration detention to hospital and to keep them in detention when treated. A different view might have been taken of whether the Secretary of State had power to do that for a serving prisoner, perhaps, as Mr Gullick said, because the former are serving sentences or are in remand at the order of the court and in places which have more extensive medical facilities.

38. Transfer from an IRC to a prison hospital is not a possibility which arises in these cases, I am told, as a matter of practicality, though it is an option available in law. But the power to transfer to a prison hospital with greater facilities than present in an IRC does not answer the issue. That is because there will still be cases where either the facilities in prison do not meet the needs which an outside hospital can do or, as here, those facilities are not practically available and needs can only be met in practical terms in an outside hospital. In those cases, the claimant's argument requires simply that the immigration detainee be released, there being no further power to detain. In my judgment, that is simply wrong.

39. The Detention Centre Rules SI No 238 2001, which govern the reporting of medical conditions of detainees who might be injuriously affected by detention, relate to detention in the IRC rather than in hospital and do not exclude transfer to hospital in detention. Rule 8 contemplates that a prisoner may be escorted in custody anywhere outside the detention centre. Whilst this would obviously cover prison transfers and court appearances, I see no reason why it would not also cover transfer to hospital for treatment. For what that is worth it supports the view that detention in places to which someone may be transferred from an IRC is lawful and supports, rather than refutes, in my judgment, that an immigration detainee can be taken in custody to hospital for treatment, kept in hospital for treatment, and returned to the IRC all in detention. This is of course not the same as compulsory treatment. There is no general obligation on an immigration detainee to accept medical treatment.

40. The second part of Ms Laing's argument is that the Secretary of State's policies nonetheless properly understood require the discharge of the claimant. That policy, it is said, has not been lawfully applied here. Although there has been some change to the shape of the argument it is clear that it is not now said that the Secretary of State's detention policy is itself unlawful, nor that the claimant was disabled or vulnerable.

41. The first policy is the Enforcement Instructions and Guidance. Ms Laing pointed out that there was a presumption in favour of alternatives to detention such as temporary

admission. Detention was a last resort but could be used with a view to removal. The policy expresses the limitations in substance as summarised by Lord Dyson in para.22 of Lumba:

> "(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 effect removal."

42. In the policy, relevant factors in relation to detention include the risk of absconding which Ms Laing said here could be controlled by a combination of a particular address and by a surety and by the absence of any risk of harm to the public if released. This was contested by the defendant in view of the claimant's stated intention in coming to the country. That is stated in his interviews rather than in his visa application, his failure to leave and going out of sight in 2008, then his further endeavours to stay, including an Article 8 claim which fell by the wayside as he lost touch with his wife and children, and including a hopeless asylum claim and, more recently, refusals to cooperate in the documentation process. The claimant has made no application either for Chief Immigration Officer's Bail or to the tribunal. The section in the EIG of particular importance is chapter 55(10):

> "Certain persons are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration accommodation or prisons. Others are unsuitable for immigration detention accommodation because their detention requires particular security, care and control ...
>
> The following are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration detention accommodation or prisons: ...
>
> • Those suffering from serious medical conditions which cannot be satisfactorily managed within detention.
>
> • Those suffering from serious mental illness which cannot be satisfactorily managed within detention (in criminal casework cases, please contact the specialist mentally disordered offender team). (In exceptional cases it may be necessary for detention at a removal centre or prison to continue while individuals are being or waiting to be assessed, or are awaiting transfer under the Mental Health Act ...)

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

There then follow the criteria for detention in prison. On health grounds, it includes this comment:

> "Separately to the issue of transferring individuals held in prison, detainees held in IRCs who are refusing food and/or fluid may be transferred to prison medical facilities if this is considered necessary to manage any resulting medical conditions."

In chapter 15.13 there is a reference to hospitals as places of detention but this is of course irrelevant both to the construction of the legislation and does not necessarily refer to hospitals in general.

43. The second policy document is the Detention Services Order 03/2013. It has no statutory basis. Its title and preamble read as follows:

> "Food and Fluid Refusal in Immigration Removal Centres: Guidance.
>
> Preamble.
>
> This order prescribes the procedures that must be adopted for handling food and fluid refusal by detainees in Immigration Removal Centres. The procedures apply to all Immigration Removal Centres."

44. The introduction is very much concerned with ensuring that those who refuse food and fluid do so with mental capacity but points out that those who do do that are entitled to do so and cannot be administered medical treatment or force-fed against their will. With proper information they can make an advanced decision about how they are to be treated in the future. Special care may be necessary to ensure that it remains applicable and their views should be monitored, but otherwise, the advanced decision must be honoured. The guidance emphasizes, however, that it is procedural guidance, urgency may prevent compliance and formulaic compliance is deprecated.

45. The role of the head of enforcement manager is explained in establishing whether a refusal of food and fluid relates to a grievance. It says:

> "43. The HO Immigration Enforcement Manager must explain to the detainee, in the presence of a second Home Office member of staff, that continued food and fluid refusal:
>
> •Will not lead to the progress of the detainees immigration or asylum case being halted or delayed;
>
> •Will not lead to removal directions being deferred;
>
> •Will not lead to permission to stay in the UK; and

> •Will not lead to release from detention.
>
> 44. The HO Immigration Enforcement Manager must write a full record of what has been said to the detainee, and both the Manager and the second Home Office member of staff must sign to say that they were both present when this advice was given. This procedure should be repeated periodically to reinforce the message."

Paragraph 46 then says this:

> "46. Some detainees choose to refuse food and/or fluids as a protest against their detention. The law presumes that an adult has the capacity to take their own healthcare decisions unless the opposite is proved. A decision to refuse food and/or fluids will not automatically entitle that individual to be released from detention. Genuine refusal of food and/or fluids can, however, in some cases lead to medical conditions that are so serious that they can no longer be satisfactorily managed in detention. In such a case, the detainee may become unsuitable for detention (although other factors may also be relevant to this decision). It is therefore important that sufficient information is available to enable a decision to be made as to continued detention."

46. One measure advocated is to encourage detainees to resume taking food and fluids. Another, after 24 hours and the involvement of senior managers, is to expedite removal, close observation and monitoring is required.

47. Under the heading "Clarify Medical Assessment" paragraphs 56 to 57 say as follows:

> "55. Where the IRC doctor has given an opinion that a detainee is no longer fit to be removed and/or no longer fit to be detained as a consequence of their food and/or fluid refusal, the doctor should be asked by the HO Immigration Enforcement Manager for details, if they have not been provided or are unclear, of the basis on which this assessment has been made. In particular, the doctor should be asked whether the assessment is based on:
>
> •Physical examinations or tests and, if so, their results and the conclusions drawn from them; or
>
> •Limited or visual observations only and, if so, the information obtained and conclusions drawn; or
>
> •The detainee's own account or information alone.
>
> 56. This will ensure that the doctor's opinion can be given due weight in deciding how to proceed, particularly when balanced against other evidence or information that may exist (eg that the detainee is in fact eating and/or drinking, even if only covertly or infrequently, or that their generally observed demeanour or behaviour does not support the doctor's

assessment). Use by healthcare professionals of the sample food and/or fluid refusal assessment record attached to this guidance will assist this process.

57. This is not about challenging the doctor's professional opinion on medical grounds. It is simply to ensure that the basis for that opinion is clear and is understood by HO Immigration Enforcement so that it can be given due weight in deciding how best to manage the detainee. Whilst it is important for doctors to express their professional view as to whether a detainee is unfit to be removed or detained as a consequence of prolonged food and/or fluid refusal, and such views must be considered very carefully, the Secretary of State has an independent decision to make in such cases, specifically, is the individual concerned suffering from a serious medical condition (ie the consequences of prolonged food and/or fluid refusal) which cannot be managed satisfactorily in detention and, if so, are there nevertheless very exceptional reasons for maintaining detention (eg high risk of public harm if released)?"

48. Paragraph 58 deals with the circumstances in which a second medical opinion may be obtained about fitness for detention. Paragraph 60 says that consideration can be given to transfer to a prison and medical facility to access the more extensive medical facilities available there.

49. The first contention under this heading is that chapter 55 of the EIG, and the DSO, do not permit transfer to hospital in detention even if the Direction does. In other words, the Secretary of State's policy has deliberately, or perhaps accidentally, but in all events expressly or by necessary implication foresworn statutory powers of detention in hospital for those who need hospital treatment and has done so when the consequences are obviously very awkward and undesirable, both in the interests of the public and in the individual detainee. I am not prepared to reach any such conclusion unless driven to it by clear words. Those are simply not present. No such conclusion is required by the principle of narrowly construing wide statutory powers since the policy does not broaden those limits already properly and narrowly construed.

50. Chapter 55.10 is clearly directed to the normal circumstances for which a policy is required: immigration detention in IRCs and prison; it says so in two places. It relates suitability for detention not to some abstract notion of a place, nor to everywhere where detention may be lawful under the Direction but to detention in dedicated immigration accommodation, that is IRCs, or prison. Both of those are forms of immigration detention accommodation. The existence of very exceptional circumstances only arises in the context of those normally unsuitable for accommodation in dedicated immigration detention accommodation, or prisons, being kept there. There is no policy concept of a person who is unsuitable for detention in dedicated immigration accommodation or prison being released from all forms of detention, absent very exceptional circumstances, even though they are suitable for detention in other places such as a hospital.

51. To my mind, although Mr Gullick jibbed at it, perhaps not seeing that it was not a point against him, the references to "detention" without any further qualifying place, as is found in the two bullet points covering those suffering from serious medical conditions or mental illness which cannot satisfactorily be managed within detention, are references to the types of detention accommodation referred to earlier. That is, dedicated immigration accommodation (IRCs) or prison. The introductory passage governs the instances below. I see the words in brackets at the end of the second bullet point printed above as supporting that. It is clear that the word "detention" there does not cover detention under the Mental Health Act. Indeed, detention is contrasted with Mental Health Act detention. The words would be otiose if the distinction did not exist between detention for the purposes of chapter 55 and detention elsewhere than in dedicated immigration accommodation or prison.

52. Thus, those who are not suitable for detention in dedicated immigration accommodation or prison do not become unsuitable for detention anywhere, simply because their medical conditions make them unsuitable for detention in dedicated immigration accommodation or prison. The consequence is not that they must be released from detention anywhere, subject only to very exceptional circumstances. It is that they must be moved to a suitable place of detention and only released if there is none again in the absence of very exceptional circumstances. This distinction was correctly drawn by Stuart J in paragraph 45(i) of his interim relief judgment referred to above. It would be odd indeed if someone whose medical condition made them unsuitable for detention in an IRC or prison, but who could readily be treated in hospital whilst still remaining in detention, had to be released from all detention on temporary admission even though the unsuitability for detention related only to detention in an IRC or prison. If it is objected that the policy does not therefore expressly cover those who require removal to hospital but who should otherwise remain in detention, the answer in my judgment is that it was regarded as so obvious as to be not worth saying that those who need medical treatment not available in an IRC or prison would, pursuant to the proper application of the policy, be transferred to hospital in detention. The policy is not looking expressly to deal with that sort of case but only to deal with those who are unsuitable, save in very exceptional circumstances, for detention in the largest and most commonly used amount of detention accommodation. The policy should not be given a strained interpretation so as to apply express words to all sorts of situations which plainly were not its contemplation to cover. The Secretary of State does not need a policy to cover a particular situation expressly for her actions in maintaining detention to be lawful or for, alternatively, the consequence of the sensible application policy to a situation to be apparent and lawful.

53. As I have said it is clear from the second bullet point that a person may be unsuitable for detention in immigration accommodation but, nonetheless, is not released. They are instead transferred to another place, that is, a mental hospital. The policy does not actually say so, but the provision for IRC detention to continue whilst assessment is awaited carries the necessary but unspoken implication that detention will continue to be suitable but it would be in another place. I do not think that that is because of the transfer powers in the Mental Health Act 1983, rather than those in the Direction. Rather, it is a reflection of the fact that the sensible and obvious consequences of

unsuitability for detention in an IRC or prison include transfer in detention to hospital for treatment. Both consequences, as I said, are too obvious to need stating.

54. Mr Gullick submitted that the right approach to the policy was to treat the two bullet points' use of the word "detention" as being qualified by such words as "anywhere where an immigrant could lawfully be detained". The first bullet point with the introduction that those normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration detention accommodation or prisons, would read:

> "Those suffering from serious medical conditions which cannot be satisfactorily managed within detention anywhere where an immigrant could lawfully be detained."

If that be the right approach then it would follow that no very exceptional circumstances would need to be considered where the condition could satisfactorily be managed within a hospital in detention, although I confess that it seems to me to reduce the words "whether in dedicated immigration detention accommodation or prisons" to nothingness.

55. The concept, which that interpretation suggests, of someone suffering from a serious medical condition which could not satisfactorily be managed anywhere, even in hospital, I also find odd, especially if the consequence is that that person must be released from detention, absent very exceptional circumstances, but with no obvious advantage to them.

56. It is only the circumstances of these cases where the conditions are readily treatable in detention in hospitals but the claimants refuse to be treated there while in detention which causes this overly constrained construction from the claimants to emerge. Each claimant had gone to hospital for treatment in detention before deciding that they would not do so in pursuit of hunger strikes aimed at achieving their release. It cannot sensibly be said that that means that the conditions cannot be satisfactorily managed in hospital. There is no need to give a strained and problematic interpretation to the policy to accommodate that.

57. The obvious premise in relation to detention in hospital for physical treatment is that there would be consent to treatment. The policy does not suggest that unfitness subsists because of a serious medical condition if treatment in hospital is refused. The serious medical condition can be managed in detention in hospital. The refusal of treatment in detention in hospital does not mean that it cannot be managed satisfactorily. In any event, that is simply not what the policy provides and it is not the sort of circumstance to which this general policy would be expressly directed.

58. But if the language of the policy could cover that position in principle, the fact that the decision to refuse treatment in detention means that the condition will not be managed at all in hospital, makes treatment in hospital no better than treatment in the IRC and shows, as the argument then comes full circle, that to the extent it can be consented to, managed in the IRC. I do not therefore accept that on the true understanding of chapter

55 there is no power to take someone to hospital in detention where their serious medical condition makes their detention in dedicated immigration accommodation or prison unsuitable, in the absence of very exceptional circumstances.

59. The Detention Services Order does not advance the claimant's contention either that once a detainee is said to be unfit for detention in an IRC he must be released even if suitable for detention and for transfer in detention to a hospital. Nothing again supports the contention that the defendant has foresworn by this policy some of the statutory powers in the Direction. Rather, chapter 55 and the DSO point in the same direction. As the title and preamble made clear, it is dealing with what happens in IRCs. It is not setting out the powers available in all circumstances to the lawful detention of those refusing food and fluids. The passage in paragraph 46 uses much the same language as chapter 55 and I give them much the same meaning. Detention here means detention in dedicated immigration accommodation. The same applies to paragraph 55.

60. The best passages for the claimant in the DSO are the last sentence in paragraph 57 and paragraph 60. Paragraph 57 deals with those who cannot satisfactorily be managed in detention and asks whether there are nonetheless very exceptional circumstances for maintaining detention such as a risk of public harm if released. That might be said to contemplate therefore that the alternative to detention, absent very exceptional circumstances, is release rather than detention in a non-prison hospital. Paragraph 60 suggests that consideration be given to transfer to a prison medical facilities where a detainee is assessed as requiring in-patient care because of the greater facility available there. These passages do not show, in my judgment, that the policies, read as a whole, make detention unlawful for those whose medical condition cannot satisfactorily be managed in an IRC or prison, again, on the assumption of a consent to treatment.

61. Paragraph 57 neither specifically contemplates treatment in an outside hospital but in detention as an alternative to release from detention, nor treatment in an outside hospital as the best solution, but still one requiring release from all detention. I see no reason to interpret that silence as ignoring paragraph 60 and the prospect of transfer to prison hospital, or as requiring release from detention if transfer to a prison hospital is not available or appropriate, but transfer to an outside hospital is capable of managing the condition. Rather, paragraph 57 it deals with a treatment in an IRC and simply does not deal with any alternative to detention in an IRC.

62. Paragraph 60 shows that transfer to prison should be considered in order to access better facilities, but obviously to do so in detention. It would be sensible for that option to precede transfer to non-prison hospitals with the security problems inherent in such a place of treatment. But it does not suggest that release should follow if prison hospital treatment is not available or suitable. The obvious implication is that hospital treatment in detention is the next best rather than release or less satisfactory treatment in the IRC.

63. Accordingly, I do not accept that the detention of someone who can lawfully be detained in a hospital outside the IRC or prison estate becomes unlawful as a matter of the Secretary of State's policy because of a need for medical treatment for a serious medical condition which cannot be managed in an IRC or prison, unless there are very exceptional circumstances.

64. If however an interpretation is given to the policy such that very exceptional circumstances are necessary for detention in an IRC to be lawful for someone whose serious medical condition cannot be treated in an IRC but could be treated in a hospital, it is obviously supplied by the fact of refusal to be treated in the hospital in detention. It is not the fact of a refusal of food or fluid which supplies the very exceptional circumstances but the refusal to consent to treatment in hospital in detention. In effect, the premise for unfitness for detention is that there would be consent to treatment and detention elsewhere.

65. I have spent a little time looking at the interpretation of policy. I have not been entirely persuaded by the Secretary of State's approach to what it means but the claimants are clearly wrong on any view that once an individual is unfit for detention in an IRC or prison, release is required. It follows that the mere fact that someone is suffering from a serious medical condition that cannot satisfactorily be managed in an IRC or in a prison upon transfer, but which can be managed in hospital, does not make his detention everywhere unlawful even in the absence of very exceptional circumstances. If the reason that it will not be managed in hospital, even though it can be managed there, is that the individual will not consent to treatment there while in detention, that does not make continued detention in the IRC unlawful. As I say it is difficult to see that it cannot be managed in the IRC, if no treatment is to take place in hospital because of the claimant's decision. The premise for the conclusion of unfitness for detention in the IRC disappears. In the alternative I accept the Secretary of State's argument that that nonetheless would be capable of amounting to the very exceptional circumstances for the continued detention in an IRC of someone whose detention there would become unlawful were he to consent to treatment.

66. On the basis which I accept that the Secretary of State does not misunderstand the true import of her policy in any significant way, the third part of the claim is that its application was nonetheless unlawful. Once there was a proper conclusion that the claimant suffered from a serious medical condition which could not satisfactorily be managed in the IRC, or prison if only for want of practical availability and accommodation, it became unlawful for the Secretary of State to maintain detention in an IRC absent very exceptional circumstances. However, this is only on the assumption that the condition could be managed in an outside hospital. If the claimant did not consent to treatment there, his condition would neither be managed more satisfactorily in hospital, nor was there any evidence that management in an IRC would then be unsatisfactory. The differences between facilities in the one and in the other would be irrelevant to the management of the condition.

67. I have set out the facts relevant to this. It is clear to me that there has never been an assessment that the claimant was unfit for detention anywhere; there has merely been an assessment that he was unfit for detention in an IRC. On neither occasion did the Secretary of State seek any clarification or a second opinion or reach a decision that very exceptional circumstances existed to warrant continued detention. The explanation for this on the first occasion was that the part C decision was not supported by any observations.

68. I am not persuaded that that is a correct understanding of what Dr Raj said. He acknowledged the want of observations and, for this purpose I am prepared to accept that the detainee's Healthcare records, which do contain observations up to a point, were not available to the IRC authorities. But Dr Raj is a GP, he knew that the claimant had been refusing food and fluids over a period albeit with intermittent resumptions. He must be taken to have had sufficient general experience to form the view that the time for specialist intervention had come. That, in my view, was what Dr Raj was conveying. If not, it was always open for the defendant to seek clarification.

69. The claimant's case was moved, however, to a higher level for consideration. I see nothing sinister in the reference to judicial review at that stage since it is obvious that a judicial review decision might require a reappraisal or release if the claimant won. There is no evidence however to explain what the Secretary of State's position is and I instead had what Mr Gullick told me on instructions. That is not satisfactory but this case has come on at some speed and the challenge which the defendant had to meet has been somewhat changeable and has not wholly focused on the way in which it developed in the couple of working days before the hearing. But the Doctor's decision was only that the claimant was unfit for detention in the IRC. That did not make detention unlawful because the claimant was clearly offered and refused to go to hospital in detention. In any event, if very exceptional circumstances were necessary, it is obvious that the Secretary of State would conclude that the refusal of the offered treatment amounted to such very exceptional circumstances as they obviously do.

70. Ms Laing criticised the letter of 31 July 2013 from the Head of Detention Operations at the Home Office to centre managers obtained after a FOI request in which the Head of Operations said:

> "As you will be aware there continues to be a number of detainees on food refusing and I would be grateful if you could send the message below to your healthcare providers.
>
> When making a medical assessment on the impact of detention on a part C or on any other document, doctors should not state that someone is not fit to be detained rather they should advise on the consequences of detention terms of medical conditions.
>
> Doctors would provide detailed information on the consequences in terms of conditions that may develop or be exacerbated, and the extent to which mitigating action could be taken."

The focus of the criticism was on the comment that "doctors should not state that someone is not fit to be detained...". There can be no objection to the rest of letter.

71. Mr Gullick said that what the letter meant was that doctors should not "simply" state that someone was not fit to be detained. I accept that is what is meant when the whole letter is read as one. It cannot be intended that doctors were to be precluded from expressing an opinion on fitness for detention, although the Secretary of State is understandably concerned to see that they explain the basis for such a conclusion, and

the more so, since it is detention in the IRC which they can advise on rather than detention anywhere. Moreover, I see nothing in the reports of the IRC doctors in these cases to suggest that they had been inhibited from expressing conclusions in their areas of expertise by any misinterpretation, as I would see it, of that letter. However, that does not really matter because if Mr Muaza is right, he should in any event have been released on 8 November, and so would be released now, or so soon after 8 November as had given the Secretary of State time to decide whether to seek clarification, a second opinion, or to reach a decision on very exceptional circumstances.

72. The defendant does not seek to defend detention on the basis that she had not had time to take these steps or to consider taking them. Her case is simpler. The fact that the claimant was unfit for detention in the IRC did not in itself make detention unlawful. I agree. The policy does not require someone to be released from detention anywhere simply because he is unfit for detention in an IRC or prison, the latter not being the situation which arises here. A decision that the claimant is not fit for detention at the IRC does not inevitably make detention in the IRC unlawful and certainly would not make detention itself unlawful everywhere in which the claimant could lawfully be detained. He can lawfully be detained in hospital. The Secretary of State would have been obliged to move the claimant to hospital after he was found unfit for detention in the IRC in order for detention to be lawful absent very exceptional circumstances. But the only purpose in doing so would have been for the claimant to receive treatment there which he could not receive in the IRC. The policy only makes continued detention in the IRC unlawful absent very exceptional circumstances where the person's serious medical condition cannot be managed in the IRC and he is to be treated for a serious medical condition in hospital. This obviously assumes that he is prepared to consent to it. There is nothing in the policy to suggest that if someone refuses to be treated in hospital that he then becomes unlawfully detained in the IRC because of his serious medical condition.

73. To put it another way, his condition, on the basis that it is not to receive treatment in the hospital as a matter of his choice, can be managed in the IRC. They were not obliged simply to release him at his option. The defendant does not defend the case on the basis of making a decision that very exceptional circumstances meant he should be kept in detention, although the proper normal application of the policy meant that he should have been released. It is that the policy does not require release in detention for hospital treatment where that treatment is to be refused. Although no such decision has been taken in the short time since 8 November in relation to very exceptional circumstances, if that were, the alternative route basis which the Secretary of State had to go down (a point raised by way of rebuttal to the claimant's arguments), it is obvious what reasonable conclusion she would reach and she would be fully entitled to do so.

74. I have also considered whether or not there is any real difference between what lawfully could be done by way of watching the claimant while in hospital, which would enable him as soon as he is charged to be re-detained, or any conditions on temporary admission which would require him to be to hospital and, when discharged, to present himself to the immigration officer waiting there so that he could be re-detained. On the assumption, which may not be correct, that all that could be lawfully arranged and be effective, would not satisfy what all the evidence shows to be his requirement, which is

release in practical terms from immigration detention. This concern is not about the precise nature of the way he might be watched in hospital, but about his freedom from the risk of detention to effect removal.

75. I have also considered whether continued detention in order to be lawful required the defendant to take the claimant to hospital against his will and to see if, faced with the hospital door, he would accept treatment in detention. I do not think that that is required. The claimant is quite weak but nonetheless is still capable of expressing his desire not to go to hospital. He has made his advanced decision.

76. The fourth part of the argument is this: the claimant argues that the power of the defendant to detain someone for the purpose of removal must run out before someone dies since there is no lawful purpose in detention for removing a dead person. The purpose of detention would have faded by that stage. This argument is correct. This is not a case in which, absent the refusal of food and fluid, the Hardial Singh principles would ultimately have been breached. It involves the application of Lumba or Hardial Singh principles in the unusual circumstances of a hunger-striker who can choose to end his hunger-strike. Once there is no reasonable prospect of removal in a reasonable time because of the health of the individual, self-induced or otherwise, there is no further power to detain. Judging whether that stage has been reached involves a judgment either (i) that the individual has reached the stage where death is unavoidable by treatment and would occur within such a short space of time that there was no reasonable prospect of the removal of the claimant at all, even were he now to consent to treatment, or (ii) that the permanent condition of survival in which the individual would live extinguishes reasonable prospects of his removal including on Article 2, 3 or 8 grounds, within a reasonable time, or (iii) that the length of time in treatment required before he could be removed, would be so long that it could no longer be said that there was reasonable prospects of removal within a reasonable time.

77. The fact that the cause of the problem is first his own refusal of food and fluid and then his refusal of possible treatment from the resulting condition, and where any objection to IRC food to the extent that that is a real objection could not apply even if he were formally in detention in hospital, does not alter the principles. The Secretary of State cannot keep him in detention simply until he is dead without considering the application of Hardial Singh in these circumstances. The claimant cannot simply say that there is no reasonable prospect of his consenting either to taking food and fluid or to the hospital treatment and therefore he must be released, any more than a refusal to cooperate in the documentation process of itself requires release. The defendant is entitled to test the refusal to the stage I have described. Otherwise a defiance can simply assert a refusal of treatment as a basis for requiring release, even though the circumstances of imminent death or serious harm, when eventually faced may create a reasonable prospect of a change of mind.

78. The actual period of detention thus far does not breach Hardial Singh principles. What stands however between removal and non-removal is the claimant's determination not to seek hospital treatment and not to cooperate in the process of documentation. There is no basis upon which I can conclude that, if treated, the claimant's condition would not improve so that he would be removed within a reasonable time without breach of

the ECHR. I do not have evidence that that stage has yet been reached, the planning for end of life and Dr Hartree's latest report notwithstanding. It is not far off. Indeed, perhaps it is possible treatment. It is of course for this court to decide whether that stage has been reached so that detention has become unlawful. I am not satisfied that that stage has been reached, so detention continues in my judgment to be lawful.

79. Like many who do not wish to be removed, he had not cooperated with the detention documentation process. That is not the basis for release by itself either. Of course, the power of detention cannot be exercised for a coercive purpose to bring about a change in the mind of someone or to punish them for non-cooperation. An individual may yet cooperate and such a stance cannot be assumed to prevail too soon. The ability to obtain documents for somebody whose identity and nationality may not be an issue should not be assumed so quickly to have run its course.

80. I do not accept the suggestion that the Secretary of State has adopted a hardline policy of saying there will be no release because this claimant is refusing food and fluid. It is clear that she would transfer him to hospital for treatment were he to consent. Then no release would eb required yet because there is still a reasonable prospect of removal of this claimant in a reasonable time. There is no requirement therefore for his release in law or policy.

81. Finally, I consider whether his non-release involves a breach of the positive obligations in Articles 2 and 3 of the ECHR. These positive obligations are not removed by the fact that the claimant is on hunger strike in full capacity. Appropriate and reasonable steps must be taken to protect life. Inhuman and degrading treatment must be avoided. Two European Court of the human rights cases are in point: Kudla v Poland [2002] 35 EHRR 11, and more so the admissibility decision in Rappaz v Switzerland [2013] ECHR 508. The former concerned a depressive who had attempted suicide in prison and alleged that he had received inadequate psychiatric treatment in prison leading to a breach of Article 3 ECHR. Paragraphs 93 and 94 provide as follows:

> "93. Measures depriving a person of his liberty may often involve such an element. Yet it cannot be said that the execution of detention on remand in itself raises an issue under Article 3 of the Convention. Nor can that Article be interpreted as laying down a general obligation to release a detainee on health grounds or to place him in a civil hospital to enable him to obtain a particular kind of medical treatment.
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> 94. Nevertheless, under this provision the State must ensure that a person is detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measures do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention that, given the practical demands of imprisonment, his health and well-being are adequately secured by, among other things, providing him with the requisite medical assistance."

82. Rappaz concerned a prisoner on hunger strike in protest against the length of his sentence and the cannabis laws which had led to his conviction and sentence. He was released to hospital for treatment but on discharge was re-arrested, re-imprisoned and his hunger strike then recommenced. He was released on house arrest whilst his case was considered in the Federal Court which concluded that force-feeding was appropriate, an advanced decision notwithstanding. He was re-incarcerated and again resumed his hunger strike. He issued a further advanced decision, was transferred to hospital, but was not force-fed. He asked for release but the authorities refused it. He eventually abandoned his hunger strike. The case summary which I have been helpfully provided with says this:

> "9. The European Court of Human Rights noted (paragraph 47) that article 2 can import a duty to take positive steps. These can include, those who are particularly vulnerable, such as prisoners, a duty to protect them against actions by which they put their own lives at risk (paragraph 48). This duty must not be interpreted as subjecting the authorities to an intolerable or excessive burden. It is not every threat to life which imposes a duty on the authorities to take specific measures to prevent its materialising. In the case of threats presented by the person himself, the Court has to consider whether, at the relevant time, the authorities know, or ought to have known that there was a real and immediate risk to the life of the person concerned, and whether, if so, they did everything which could reasonably have been expected of them to avert that risk (paragraph 49).
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> 10. In the case of prisoners (the French word 'détenus' is used) who, voluntarily, or involuntarily, put their lives at risk, the Court recalls that the authorities must discharge their functions in a way which is compatible with the rights and freedoms of the individual. That being so, article 2 does not oblige a State to release a prisoner (again, 'détenu' is used) on health grounds. The Court may not substitute its own assessment for that of the domestic authorities, provided that they have broadly met their duty to protect the physical integrity of the prisoner, in particular by providing appropriate medical treatment (paragraph 50).
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> 11. With regard to prisoners who risk their own lives by going on hunger strike, the Court recalls that the consequences of putting pressure on the authorities will not entail a breach of the Convention, in so far as they have properly examined and handled matters. This applies just as much when a prisoner clearly refuses all interventions, even if his state of health would threaten his life. Finally, the Court recalls that when it considers whether there is a causal link between the death of a prisoner on hunger strike, and the refusal of the authorities to release him, it takes into account whether, in the prison setting, the prisoner has been deprived of such medical attention as he could have obtained when at large (paragraph 51).
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> 12. The Court recalled, in relation to the facts, that the applicant's hunger

strike was motivated not by a desire to end his life, but by a desire to put pressure on the authorities, in order to achieve a change to the drugs laws and to obtain a shorter sentence. This was not a case in which the Court had to consider whether the State had violated the applicant's right to decide on the time and manner of his death, as it might do within the framework of article 8, but to ensure that the State had properly observed the positive duty imposed on it by article 2, to preserve the applicant's life (paragraph 52).

13. When a prisoner embarks on hunger strike, the consequences for his health will not entail a breach of the Convention so long as the domestic authorities have properly investigated and handled the situation. This is particularly so when the prisoner persists in refusing food, despite the deterioration in his health. The Court referred to Horoz v Turkey application no 22913/2004, 10 November 2005, in which it did not find a breach of article 2. The applicant's son had died in the penal unit of a hospital, where he had been hospitalised, from the consequences of a hunger strike which he had refused to abandon. In the light of the facts that the authorities had properly investigated and handled the situation, that the individual had refused all treatment, and nothing indicated that he had not benefited, in the prison setting, from any medical care which would have been available outside, the Court concluded that the refusal to release him did not entail a violation of article 2 (paragraph 53)."

83. On the facts, the court found that the necessary steps to protect life and health had been taken. The authorities had properly investigated and handled the situation. They had sought to protect life and the applicant had not been deprived of any care which would have been available to him had he been on hunger strike at large. Those last words are important, since that was the test, not whether had he been at large when he would not have been on hunger strike having achieved his objective. Article 3 was considered at paragraphs 16, 17 and 19:

"16. As to article 3, the Court noted that treatment must attain a minimum level of severity for Article 3 purposes and recalled that the fact that those on hunger strike have inflicted harm on themselves does not in any way absolve the State from its duties under article 3 (paragraphs 60-62). Moreover, though the Convention does not in principle entail an obligation to release a prisoner on health grounds, a decision to order the return to custody of a person on hunger strike may disclose a breach of article 3 if that person is suffering from permanent health consequences, such as, for example, Werneicke-Korsakoff syndrome, among others (see Uyan v Turkey application no 7454/2004, 10 November 2005, paragraphs 44-45 and Balyemez v Turkey application no 32495/2003, 22 December, paragraphs 90-96) (paragraph 63).

17. The Court also recalled that the consequences of putting pressure on the authorities will not entail a breach of the Convention, in so far as the authorities have properly investigated and managed the situation. Such is

> the case with a clear rejection of all intervention expressed by a hunger striker, even if his state of health is a threat to his own life (paragraph 64)...
>
> 19. The Court, applying those principles to the facts, recalled that the physical and mental suffering of the applicant were a direct consequence of his choice not to eat, a choice he could have reversed at any time. But the Court was, nevertheless, not relieved of the obligation to ensure that the domestic authorities had complied with their obligation to provide the applicant with conditions of detention which were compatible with his state of health (paragraph 66). The applicant was returned to custody twice, but did not claim to be suffering from any permanent ill effects such as Wernicke-Korsakoff syndrome. The Court concluded that returning the applicant to custody did not, of itself, constitute a breach of article 3 (paragraph 67)."

84. Both claims that Article 2 and Article 3 were breached were rejected as manifestly unfounded. On the facts of this case the claimant's reasons for his hunger strike had been investigated. He has full capacity, having been assessed on at least two occasions. He made an advanced decision. He has had legal advice over some months. He has been assessed by prison doctors and by psychiatrists on two occasions. He has also had access to a doctor from Medical Justice, another doctor and a psychologist. Although there is a difference in emphasis there is no basis for coming to any different conclusions about his capacity from those reached by Dr Khan. He has been offered food and fluid, medical observations and hospitalisation on many occasions. There has been no complaint about his health care nor about the way in which the defendant plans for his comfort and care at the end of life. Short of releasing him, which the defendant is not obliged to do, there was nothing more which can be done.

85. I appreciate that the public interest arguments may be stronger in Rappaz and in respect of serving prisoners and that a risk of absconding might be reduced by conditions, although that is a disputed judgment. But, in the end, the decision to start, maintain and continue the refusal of food and fluid to the end is for the claimant to make. His detention does not become unlawful simply because he is determined on that outcome. I reject the argument that ECHR rights require his release now from detention or at an earlier stage than would be arrived at by the application of the common law principles to which I have referred. Accordingly, I reject this application for judicial review ably though it was argued on behalf of the claimant. Although there are parts of both grounds which do I not regard as arguable I grant permission to apply for judicial review but refuse relief substantively. There are important issues and if the case is to be appealed this will avoid unnecessary procedural issues or in arguments best considered as a whole.

86. Adda. The argument can be taken more shortly. He is an Algerian national aged 26 whose six-month leave to enter as a visitor expired on 3 March 2013 when he became an over-stayer. On arrest on 17 April he claimed asylum and his appeal against his refusal was dismissed on 12 June. He had an emergency documentation interview on 16 July and the application pack was then sent to the Algerian consulate and on to the

authorities in Algeria. There are two bases for the challenge. The first is the same as in Mr Muaza's case, namely that once a doctor had expressed the view that he was unfit for detention his detention became unlawful and in breach of his human rights. Second, but with less hope, that his detention was unlawful from the start since there was never a reasonable prospect of removal to Algeria within a reasonable time in view of the documentation required and if not unlawful from the start it became unlawful later on.

87. Even if my views on the principle of lawfulness of detention in hospital or after a decision that someone was unfit for detention in an IRC are arguably wrong, this case is not arguable on its own facts. Again it is not disputed but that Mr Adda had at all times capacity to make his own decision about the refusal of food and fluid, and to refuse hospital treatment for conditions he knew would lead to his death or long-term injury if left untreated. It is to be noted that he had refused food at the end of May and in June but resumed food at some time before July. He made an unsuccessful bail application on 19 August. He had been happy to go to hospital in September in detention for treatment for a wrist injury incurred playing football. On 24 to 26 September he started to refuse food and later to refuse fluids. He was released on 17 October. He refused to cooperate with medical treatment in the IRC and to consent to hospital treatment. This was always a protest against his immigration detention. Mr Adda was again placed in the assessment care in detention and team work, the self-harm and suicide prevention framework on 26 September and on 29 he was graded black in the BRAG code. There was an attempt at suicide on 26 September. On 30 September he refused to continue an interview with medical staff saying that he wanted to die if he was not released and just wanted to be released. He refused to sign an advanced decision but it was noted he had full capacity. He was reviewed by health care and they concluded he was fit for detention. Although he said that he would rather die than return to Algeria, he was not thought to be suicidal. On 1 October he started refusing fluids. Dr Hartree's report of 4 October on Mr Adda concluded that he was physically and mentally unfit for detention. That, I do not think it can be argued, nor was it, made his detention unlawful.

88. The claimant was still assessed as fit for detention by IRC staff on 5 October. He was seen daily by a member of the medical staff, sometimes nurses, sometimes doctors and sometimes by the mental health team. On 6 October he refused hospitalisation as he did on the 7th, repeating his wish for freedom or to die and, again, he refused hospitalisation on 11 October. Consideration was given to expediting his case. He was told and said that he understood that refusing food and fluid would not lead to permission to stay or to release. He said he just wanted his freedom.

89. He was first assessed by the IRC's Dr Oozeerally as unfit for detention on 14 October 2013. Part C reads:

> "This detainee is food refusal day 27 with minimum fluid intake. He has a low BP 94/77 and since his arrival ... 10/13. Day 13 of refusal has lost 4kg, 8.3 per cent of his body weight. He is clinically dehydrated and weak with generalised abdomen pain. He has refused hospitalisation and blood tests. In his current state I feel he is no longer fit for detention as Harmondsworth can no longer manage his mental needs."

This was logged as received in the general case information database, GCID, on 15 October. On 15 October he again refused to go to hospital. There was what is what is called a tactical meeting on 15 October at which it was decided he was unfit for detention, that is to say no clarification or second opinion was sought. Dr Oozeerally had explained the observations and tests on which his opinion was based. His opinion was limited to unfitness for detention in Harmondsworth but must have been assumed to be good for IRCs in general.

90. On 15 October the outcome of the tactical meeting was that Mr Adda was unfit to be detained but they needed to await the outcome of the judicial review on 18 October 2013. If successful, he would be released into section 4 accommodation and the tactical release plan was to be examined. I see nothing unlawful about awaiting the outcome of the judicial review before reaching any actual decision on where he should go. He was released on 17 October after arrangements were made for him to be taken by ambulance to Hillingdon Hospital at which it was thought he needed treatment. There was some thought about a private address to which he could go. He was taken to Hillingdon Hospital by the defendant but not admitted. He did not sleep where required by the conditions of release, but his solicitors and Medical Justice obtained some accident and emergency treatment for him at Charing Cross as an outpatient and he received medication.

91. I start my consideration of facts on the premise, contrary to my views in Mr Muaza's case, that upon the receipt of the Part C the defendant was obliged to release Mr Adda save that, as Ms Laing accepted, that did not require immediate release: there might be questions of a second opinion, clarification, where he was to be released to, under what conditions, what sort of accommodation was required and whether a transfer to hospital under detention should be facilitated. Ms Laing accepted that there would be a day or two before detention became unlawful following receipt of a decision by a doctor that an individual was unfit for detention.

92. Even on her case, I do not think that from a report dated 14 October, received on 15 October, to the consideration of the situation and while judicial review was going on and of what to do with him, to release on 17 October can possibly be regarded as involving a period of unlawful detention, even for so much as one day. Nor do I see anything in the treatment made available in detention which could possibly be regarded as involving a breach of the ECHR.

93. Ms Laing submitted that his release might be thought not to have been for the reason given, namely that the Secretary of State had found out that there would be a significant delay in obtaining the ETDs, and by inference he was released because he was refusing food and fluid and the Secretary of State did not want to admit as much as the reason. This was made much more explicit by Ms Braganza in reply, I do not think that such a submission can be accepted without much better evidence to back it up. As I shall come to, the circumstances in which the delay appeared do not mean that the Secretary of State was obliged to release him on Hardial Singh grounds, although in the management of the retained estate she was entitled to do so. I see nothing to support the suggestion that she realised his detention had become unlawful on the grounds of the effect of his hunger strike on his health. There is nothing in the contemporaneous

records to back up that speculation. In particular, on 17 October, the GCID includes this:

> "Following a conversation with Hugh Ind on this case, in view we have no realistic timescale for document issuance, this case is to be released. Although he is an FFR case, as we are releasing due to other reasons, Hugh had said ministers need to have notification (however Hugh was involved in the process discussion)."

That same record refers to discussions about whether he Then needs to be taken to hospital.

94. The second ground is that detention continued beyond the point at which there was a reasonable prospect of removal within a reasonable time, or even began when there was no such prospect, having regard to what was known about the time it took Algerian authorities to issue ETDs. I do not accept the argument that the detention was unlawful from the start even while the appeal was in progress. On arrest as an over-stayer he made an asylum claim, the appeal rights in respect of which were not exhausted until 12 June. I see no reasonable basis for saying that the time it might take to take get an ETD from Algeria meant that, in effect, no Algerian requiring an ETD could lawfully be detained until an ETD had been requested or obtained.

95. On 16 June consideration was given to what documents needed to be obtained and they were obtained. Mr Adda was interviewed for the ETD on 16 July. There was no undue delay in securing that interview. The ETD pack was sent to the Algerian consulate, including apparently a copy of a valid passport. The Algerian consulate handed a letter dated 7 August to the defendant on 19 August saying that the application had been sent to the relevant Algerian authorities for identification. The defendant may have hoped for an early answer, but through this period, she acted with reasonable promptness. I see no basis for saying that the period up to 17 October was unreasonably long unless information about the time taken to progress Algerian ETD showed that there was no reasonable prospect of removal in a reasonable time. Ms Laing referred to two cases: R(on the application of Lamari) v Secretary of State for the Home Department [2013] EWHC 160 (Admin), HHJ Cotter QC, and R(on the application of Azaroal) v Secretary of State for the Home Department [2013] ECHR 1248 (Admin) Mr Robin Purchas QC, (Sitting as a Deputy High Court Judge). Both concerned the time taken to get EDTs from Algeria. The facts in the form in the first case include a comment in a detention review in May 2011 that:

> "Currently the timescale for obtaining an ETD is 12 months. Therefore removal is not imminent."

I note that that is only a comment from a detention review in 2011 and not a finding good for all time, and the test for the lawfulness of detention does not require removal to be imminent, even if that is a basis upon which for the management of the estate, and I do not know, the defendant releases some detainees from detention.

96. Mr Purchas had greater detail closer to the time relevant to this case. A witness statement in April 2013 from the defendant said that an application for ETD to the Algerian consulate with no specific supporting evidence could take 6 to 12 months for a response depending on the address details. The last known address in Algeria is apparently of some importance. The Algerian consulate had requested the Home Office not to seek a review of cases before 3 months had elapsed since the submission of the documents to it since that was the average timescale for clarification checks to be completed. It had been anticipated, at least at the end of September, that the ETD would take 3 months from 22 July when the pack was sent to the Algerian consulate. Efforts were being made to expedite it. That in my judgment would have meant that the ETDs could reasonably have been expected by 22 October and there would have been scope for leeway had a timetable had meant that the period could still be foreseen.

97. On 15 October the tactical food and fluid meeting with many others, including the complex removals team and the country of returns and operations strategy team, the latter told the meeting that there was at present, after a phonecall, no present estimated timescale for the issuance of these Algerian documents and that was fed into the release decision guiding the estimate as to how long removal might take. I do not conclude that detention would necessarily have been lawful after 22 October or thereabouts, but I regard it as unarguable that it was unlawful before that date on Hardial Singh grounds, some days after the claimant was in fact released. Accordingly, on both grounds, taking them at the most favourable to the claimant, I am satisfied that the case is unarguable on its facts and refuse permission to apply for judicial review.

98. MS GREY: My Lord, in those circumstances, can I ask for an order formally recording what your Lordship has already said in the judgment, that is, permission granted, but the application refused in the first and permission refused as unarguable in the second.

99. MR JUSTICE OUSELEY: Yes.

100. MS GREY: Secondly we ask for our costs on the usual basis given that the claimants are legally aided.

101. MR JUSTICE OUSELEY: Are you asking for costs in Adda?

102. MS GREY: Yes, I think because it's a permission application of course the normal procedure would be merely to ask for the costs of the acknowledgement of service but then these cases have taken a rather exceptional basis so we would simply ask for our costs. But as I say it is on the basis that these costs would have to be assessed under the Legal Services Act.

103. MR JUSTICE OUSELEY: Ms Laing?

104. MS LAING: My Lord, in relation to costs I am asked to mention that these cases do raise broader issues than simply the cases of the two claimants so I would ask for you to bear that in mind on the issue of costs and to make an order.

105. MR JUSTICE OUSELEY: What do you say, that I issue no order as to costs?

106. MS LAING: Yes. Can I raise two more matter matters, my Lord. The first is permission to appeal. I would be applying for permission to appeal to the court in the Muaza case. As your Lordship recognised, in a sense the three arguments do need to be considered together, so I would be asking for permission on all three grounds.

107. MR JUSTICE OUSELEY: Yes. Have you said all you want to say about costs?

108. MS LAING: Yes.

109. MR JUSTICE OUSELEY: What do you want to say about the permission to appeal in Muaza?

110. MS GREY: My Lord, I think it is quite difficult for me to say anything other than the generalities. The application I understand is opposed. Your Lordship has considered this matter in great detail over the course of some two days. I do not think it can sensibly be said (Inaudible) general importance of issues.

111. MR JUSTICE OUSELEY: Yes. I think this is a case where it would be wrong to refuse permission. Whatever my views about the merits of some of the arguments, I think I made clear my view about some of them but I think it would be wrong to divide it up which is what I said so I will leave it if an appeal is pursued for Ms Laing to decide whether all points are pursued and whether the arguments are adjusted. But that will be a matter for counsel to decide. I will grant permission and I will not limit it in relation to grounds.

112. MS LAING: I am grateful.

113. MR JUSTICE OUSELEY: That deals with that. But then it comes back to the question of costs. True it is that in Muaza this is a case which involves wider issues, I accept, and those wider issues need to be resolved. I am not persuaded though that in the case of Muaza that's a reason for a different order in relation to costs. Subject to whatever is the appropriate formulation in relation to somebody who is legally aided, there will be an order for costs subject to any required assessment process. I think the provisions have changed from the convenient form you could previously adopt without leave of the court. But there has to be a further judicial intervention before any costs can be pursued. I imagine your solicitors are not very much more aware of the precise formulation.

114. MS GREY: My Lord I think we can liaise and check since neither of us have come up with the correct formulation. Assessment under section 11 of the Courts and Legal Services Act, or something to that effect.

115. MR JUSTICE OUSELEY: If you can sort out what the correct form is, I really do not want to have to get involved in that process of assessing, which I think may be required. Assessing what the contribution should be. In the present circumstances I would think it is likely I would assess it as nil.

116. MS GREY: My Lord, I do not understand, that's a decision for your Lordship, at least in the absence of argument. Can we just leave it?

117. MR JUSTICE OUSELEY: Yes, I will see what you say. So far as Mr Adda is concerned, I think that's the amount for costs in the acknowledgement of service only. Same principles will apply to those costs as well.

118. MS GREY: Yes. My Lord I am being given a copy of an order dated 28 October which I think must be an earlier costs order in this case. It simply says there will be detailed assessment of the claimant's publicly funded costs in accordance with the Community Legal Services (Costs Regulations 2000). If we can check that and agree that this is the correct formulation.

119. MR JUSTICE OUSELEY: Check whether that's the right one. I thought it was more contemplated now. The mere fact we did it once didn't mean we did it right.

120. MS GREY: In any event, I think your Lordship's determination on the principles which we need to apply is plain: costs in the Muaza case and costs of the acknowledgement of service in the other case.

121. MR JUSTICE OUSELEY: Yes, that is right.

122. MS GREY: I am sure we can liaise.

123. MS LAING: My Lord, might I raise one matter further. It's really producing a copy of your Lordship's judgment as quickly as possible. I would ask for the transcript to be expedited. I am not sure how quick that would be. What I was going to suggest was that if it turned out that it might be quicker we would seek to agree a joint note of your Lordship's judgment and submit it to your Lordship.

124. MR JUSTICE OUSELEY: By all means. I do not know what your plans are for going to the Court of Appeal, the logistics of it, rather than the principle of it.

125. MS LAING: But the logistics would be likely to involve showing the Court of Appeal a copy of your Lordship's judgment.

126. MR JUSTICE OUSELEY: Yes. I will have a word with the shorthand writer. I am more than happy, if it's not available, to approve a note or you just do the best you can if there is not time to approve it.

127. Monday would be the earliest you could get a corrected transcript.

128. MS LAING: Can I thank your Lordship very much for producing a judgment under the pressure of time.

129. MR JUSTICE OUSELEY: Not at all. There are some infelicities and repetitions that I might remove if I get the chance, but the answer will be the same.