Neutral Citation Number: [2011] EWHC (Admin)

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

CO/123/2011

Date: 7 April 2011

Before:

HIS HONOUR JUDGE WAKSMAN QC
(sitting as a Judge of the High Court)

THE QUEEN (On the application of ALEXANDER THOMAS CONDLIFF)

Claimant

- and -

NORTH STAFFORDSHIRE PRIMARY CARE TRUST

Defendant

Richard Clayton QC and Peter Telford (instructed by MPH, Solicitors) for the Claimant
David Lock (instructed by Mills & Reeve LLP, Solicitors) for the Defendant

Hearing dates: 23 and 24 March 2011

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

INTRODUCTION

1. This is a claim for judicial review of the decision of the Defendant, North Staffordshire Primary Care Trust ("the PCT") made on 13 October 2010 whereby it refused a renewed individual funding request ("IFR") by the Claimant, Mr Condliff, for laparoscopic gastric by-pass surgery to be funded by the NHS. Mr Condliff is morbidly obese, with various associated co-morbidities and his health is deteriorating. Accordingly, this claim has been dealt with on an expedited basis and by holding a "rolled-up" hearing. The points raised before me are clearly arguable and therefore at the outset of this judgment I grant permission to apply for judicial review.

THE BASIC FACTS

2. Mr Condliff is 62 and lives in Stoke on Trent, within the catchment area of the PCT. As a result of congenital problems, he developed diabetes and other health disorders. Following problems with treatment (or the lack of it due to a severe needle phobia), the insulin he should have received over a number of years was not delivered as timeously or as effectively as it might have been. The diabetes and other health problems associated with it worsened. Following a course of insulin delivered in an acceptable manner, the Claimant developed a gross appetite and began to gorge himself. His weight increased and his health problems multiplied. He tried all other relevant non surgical interventions including dietary and lifestyle and drug interventions for his gain in weight but was not successful. He is rendered morbidly obese with a BMI (body mass index) in excess of 40 kg/m2. His co-morbidities include renal impairment, hypertension and obstructive sleep apnoea.

3. Laparoscopic gastric by-pass surgery ("the Surgery") is a form of bariatric surgery. It is an alternative to open surgery which is too dangerous to be performed on Mr Condliff. It is common ground that it is clinically appropriate for Mr Condliff to seek the Surgery which may reduce his weight and alleviate his other serious symptoms.

4. The relevant primary policy of the PCT ("the Primary Policy") was to provide the Surgery as a routine operation to all those whose BMI was more than 50, for whom the clinicians say it is necessary and who then consent to it. Mr Condliff was not eligible because his BMI was less than 50. He was however able to make an IFR for the Surgery on the grounds of exceptionality which he did on 2 February 2010 through his GP Dr Linney, supported by various specialists who had been treating him. At a meeting of the PCT on 11 March 2010, this was rejected, as notified to him in a letter dated 17 March 2010. Over the next 6 months his condition deteriorated and a request was made to the PCT by Dr Linney in a letter dated 22 September 2010 with enclosures to ask the PCT to reconsider the IFR application. But originally they were sent to the wrong address. Later the letter was forwarded by e-mail to the PCT but without any enclosures. Accordingly, the only material before the PCT was the letter itself. See paragraph 25 of Dr Harvey's witness statement.

5. In the letter Dr Linney referred to Mr Condliff's various clinical conditions on page 1 and on page 2 said that she had seen a real deterioration in his physical and mental condition in the three months while she had been away on leave and asked for the earlier decision to be reconsidered. She referred to the fact that he now had to use a wheelchair and apart from medical visits was housebound. He could no longer attend Church, one of his previous interests, nor could he play the guitar due to swelling and pain in the hands. His diabetes had caused problems in the left eye and as he had almost reached the limit for laser therapy and

as it was likely to deteriorate further, it was in effect a lost cause. His lack of mobility had caused him to become depressed and withdrawn, he suffered from incontinence and his wife had to get up several times in the night to address this. Nor could he shower or dress himself. Dr Linney said that the Surgery would help to control his diabetes and hence the related retinopathy and renal failure. She referred to the fact that if he were in the Stoke PCT area he would have qualified for the Surgery because he had a BMI of over 35 (it was now 43) and had several co-morbidities and that PCT had a policy with a lower threshold for surgery.

6. The PCT did not consider that these factors mentioned merited reconsideration, as it said in the decision letter under challenge dated 13 October 2010. It said that the public health consultant who reviewed the letter felt that there was no new evidence for the panel to consider and that the additional information contained in Dr Linney's letter did not demonstrate exceptionality.

THE IFR POLICY

7. The PCT's IFR policy provides at paragraph 4.1.2:

> "Where a particular treatment or procedure is not part of an agreed pathway or existing commissioned service, it will not be routinely funded. The patient's request for funding for such a treatment or procedure will be considered under the terms of this Policy".

8. It then explains that treatment will only be funded for individual patients by the PCT, where it is refused to other patients with similar clinical circumstances, if the patient is able to show that he or she is exceptional. The test for exceptionality is in paragraph 4.2.4:

> "The application should demonstrate each and all of the following three criteria:
>
> 1. It does not in fact seek to introduce a new treatment for a definable group (however small). Such cases constitute service developments and should be introduced via the PCT's annual prioritisation process.
>
> 2. The patient is significantly different from the general population of patients with the condition in question who are currently excluded from funding.
>
> 3. The patient is likely to gain significantly more benefit from the intervention than the average patient with the condition"

9. The IFR policy then provides at paragraph 4.2.5:

> "Social factors (for example, but not limited to, age, gender, ethnicity, employment status, parental status, marital status, religious/cultural factors) will not be taken into account in determining whether exceptionality has been established"

("the Social Factors Exclusion")

10. The justification for this approach is contained in Appendix 1 to the IFR policy ("the Appendix") as follows:

"b) Non-clinical factors:

> Patients often seek to support an application for individual funding on the grounds that their personal circumstances are exceptional. This assertion can include details about the extent to which other persons rely on the patient, or the degree to which the patient has contributed, or is continuing to contribute, to society. The PCT understands that everyone's life is different and that such factors may seem to be of vital importance to patients in justifying investment for them in their individual case. However, including such non-clinical, social factors in any decision-making raises at least three significant problems for the PCT:

> Across the population of patients who make such applications, the PCT is unable to make an objective assessment of material put before it relating to non-clinical factors. This makes it very difficult for the Panel to be confident of dealing in a fair and even-handed manner in comparable cases. **[1]**
>
> The essence of an individual funding application is that the PCT is making funding available on a one-off basis to a patient where other patients with similar conditions would not get such funding. If non-clinical factors are included in the decision making process, the PCT does not know whether it is being fair to other patients who are denied such treatment and whose social factors are entirely unknown. **[2]**
>
> The PCT is committed to a policy of non-discrimination in the provision of medical treatment. If, for example, treatment were provided which had the effect of keeping someone in paid work, this would tend to discriminate in favour of those of working age and against the retired. If a treatment were provided differentially to patients who were carers this would tend to favour treatment for women over men. If treatment were provided in part on the basis that a medical condition had affected a person at a younger age than that at which the condition normally presents, this would constitute direct age discrimination. **[3]**
>
> Generally, the NHS does not take into account social factors in deciding what treatment to provide. It does not seek to deny treatment to smokers on the grounds that they may have caused or contributed to their own illnesses through smoking, nor does it deny treatment to those injured in dangerous sports in which they were voluntary participants. **[4]**
>
> In general, the NHS treats the presenting medical condition and does not inquire into the background factors which led to the condition. The policy of the PCT is that it should continue to apply these broad principles in individual applications for funding approval. The PCT will therefore seek to commission treatment based on the presenting clinical condition of the patient and not based on the patient's non-clinical circumstances. **[5]**
>
> In reaching a decision as to whether a patient's circumstances are exceptional, the Panel is required to follow the principle that non-clinical or social factors including social value judgements about the underlying medical condition or the patient's circumstances are never relevant. **[6]**
>
> Patients and referring clinicians are asked to bear this Policy in mind and not to refer to social or non-clinical factors to seek to support the application for individual funding".

(numbers in square brackets added)

11. Under the policy once it was established that the applicant did not qualify under the Primary Policy, the IFR would be screened to see if it showed *prima facie* evidence of exceptionality. See para. 5.2.1. If not, it would be refused at that stage. Otherwise, it would be referred to the full panel for consideration which is what happened in March 2010. Under para. 5.5.3 the Panel had a discretion to re-consider cases if genuinely new evidence was produced demonstrating that the patient was exceptional. Para. 4.4 provided for a right of appeal and para. 4.5 gave a separate right to make a complaint.

12. It is not in dispute that this policy was known to Mr Condliff's medical advisers including Dr Linney, and indeed it is available on the internet.

THE GROUNDS OF CHALLENGE

13. There is no challenge under judicial review or human rights law to the Primary Policy which excluded *en bloc* those who sought the Surgery but who had, like Mr Condliff, a BMI of less than 50, although there was such a challenge, originally. Nor is there any challenge to the IFR policy generally including the test for exceptionality.

14. The only aspect of this policy which is challenged is the Social Factors Exclusion. This is said to contravene Article 8 of the ECHR ("A8"), and so the decision made in conformity

with it, namely 13 October 2010 is itself said to be in breach of A8. This forms Ground 1 of the present claim. There is however no challenge to the Social Factors Exclusion on the basis of irrationality. It is a pure human rights point.

15. Ground 2 is an allegation that even if the decision was justified under A8, it contained no reasons as to how that conclusion was reached, as required by Article 6 of the ECHR ("A6").

16. Ground 3 alleges that the decision of 13 October involved various breaches by the PCT of its own IFR policy.

17. Finally, Ground 4 alleges that in general there were no or no sufficient reasons given and that in the absence of such reasons, the decision overall should be regarded as irrational.

18. There is no challenge to the original decision of 17 March 2010 though Mr Condliff says that it is necessary to have regard to it when considering the challenge to the later decision.

GROUND 1

Article 8

19. This provides as follows:

> "1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others"

Factual Matters

Scope of the Social Factors Exclusion

20. The Social Factors Exclusion is set out at paragraphs 9 and 10 above. One notes that in the Appendix the term "non-clinical factors" is sometimes used including the heading. Some social factors might have direct clinical implications and if they do it would seem unlikely that they would be ruled out. This view is supported by the examples given in the policy of those social factors which would be ruled out eg social value judgments about smokers, an applicant's contributions to society, the value of keeping an employed person in work, where there would be no possible clinical connection.

21. This approach is also reflected in the policies adopted by two other PCTs to which I was referred (on the question of proportionality). First, NHS Bedfordshire's IFR Policy states as follows under "Determination of Exceptionality":

> "Personal and social circumstances are unlikely in themselves to be sufficient to demonstrate exceptional circumstances. They will only be taken into account by the Individual Funding Panel where these circumstances contribute to the determination that the patient's clinical circumstances are significantly different to the general population with the same condition and the patient is likely to gain significantly more benefit from the treatment being provided."

22. I was also referred to the East Lancs. Blackburn with Darwen PCT IFR Policy. Under "Equity" this states that:

> "..the Committees will not discriminate on the grounds of personal characteristics such as age, gender sexual orientation, gender identity, race, religion, lifestyle, social position, family or financial status, intelligence, disability physical or cognitive functioning. However in some circumstances these factors may be relevant to the clinical effectiveness of an intervention and the capacity of an individual to benefit from the treatment."

23. Although the two other policies appear to be somewhat more nuanced, I do not see any essential difference between their approach and the Social Factors Exclusion. If the social factors have a clinical significance they will not be "non-clinical factors".

The NHS General Approach

24. Mr Clayton QC for Mr Condliff questioned whether the statement in the Appendix at [4], "Generally, the NHS does not take into account social factors in deciding what treatment to provide." was really correct. In the absence of clear evidence to the contrary I would be slow to conclude that such a statement in a PCT document was significantly inaccurate. The particular examples given of the NHS's general approach concerned its policy not to deny treatment to smokers or those who engage in dangerous sports. There is no reason to suppose that this is not so. No evidence has been shown to me which suggests that the NHS does take into account purely social factors when allocating treatment.

25. Mr Clayton did, however, refer me to a document produced by The NHS Confederation which is an independent body for the organisations that make up the NHS. It is not an NHS policy document. The document is called "Priority Setting: managing individual funding requests." It is said that this document shows that there is no general approach in the NHS to exclude social factors when considering what treatment to provide. But what it said, in 2008, was that the PCTs are increasingly adopting policies that only allow clinical considerations and the document itself urged caution against taking a different approach unless what might otherwise be regarded as a social factor, like employment, has clinical implications in that particular case (see page 5). This is similar to the approach taken by the Bedfordshire and East Lancs. PCTs. I do not regard this document as demonstrating that the statement in [4] is wrong.

Social Factors and A8 Private Life Factors

26. These two sets of factors are not synonymous. First, some private life factors may have clinical significance in which case they will not be rejected. Second, some social factors do not amount to private life matters. It all depends on what the social factors are. For example factors advanced on behalf of the applicant concerned with employment status or ethnicity may have nothing to do with A8 at all. So to characterise the Social Factors Exclusion as a blanket exclusion of A8 factors is simply wrong in my view.

The factors invoked and the decision in this case

27. The only material before the PCT was the letter of 22 September 2010. See paragraph 5 above. In his submissions Mr Clayton concentrated on the factors set out in paragraph 28 of his skeleton argument but these, drawn from Mr Condliff's witness statement in these proceedings, were somewhat more extensive than the contents of Dr Linney's letter.

28. Mr Condliff's challenge to the decision of 13 October proceeded upon the basis that the Social Factors Exclusion was actually applied to the factors invoked in his case by Dr Linney. In fact I have very considerable doubt about that. In paragraph 26 of his witness

statement, Dr Harvey, the physician who considered whether Dr Linney's letter of 22 September 2010 amounted to material to justify a reconsideration of exceptionality (and who had sat on the original IFR panel in March 2010), stated that he reviewed the letter to see if it contained any fresh evidence that could potentially demonstrate exceptionality. He said that it did not. He said that the material in the letter showed how Mr Condliff's condition had worsened in the last six months but that sadly this deterioration in his clinical condition was consistent with his co-morbidities which was foreseeable if he could not otherwise lose weight. In paragraph 27 he said that he formed the view that the changes in Mr Condliff's condition were well within the range of clinical indicators which could be expected for someone in his situation and while the information showed a sad but predictable decline, it was not evidence that his condition could now be said to be exceptional. (For the reasons given in paragraph 94 below I see no reason not to have regard to Dr Harvey's witness statement.)

29. There is nothing in that passage to indicate that Dr Harvey disregarded the factors advanced by Dr Linney because they were merely "social". Rather, he found that they did not advance the case on exceptionality because they arose from the existing co-morbidities.

30. That said, since Dr Harvey's evidence did not address specifically whether he disregarded any factor because it was "social" and because the Social Factors Exclusion is at least capable of excluding factors which might fall within the wide definition of private life under A8, and finally because some of the matters raised in Dr Linney's letter could be regarded as A8 private life factors, it is still necessary for me to consider the lawfulness or otherwise of the Social Factors Exclusion itself.

The nature and scope of the objection in Ground 1

31. While it is alleged that the Social Factors Exclusion (and thus any particular decision which applied it) amounts to an unjustified breach of A8 it is not alleged that this is because the PCT was guilty of interfering with Mr Condliff's A8 rights, prohibited by the first part of A8 (2). Rather it is said that this is one of those cases where a positive obligation upon the public authority (here the PCT) has arisen and the Social Factors Exclusion put the PCT in breach of it. In this regard I accept the submission made by Mr Lock that the ECHR is principally negative in quality and the primary purpose of A8 is to prevent arbitrary state action which restricts private and family life. The duty is to "respect" private life not to deliver an unrestricted private and family life for all. Any positive obligations which arise are likely to be limited.

32. The nature of the claimed positive obligation is stated in paragraph 38 of Mr Clayton's skeleton argument as follows:

> "The prohibition plainly breaches the PCT's positive obligation to put in place a regulatory framework of adjudicatory and enforcement machinery in place to safeguard the Claimant's Article 8 rights."

33. It must follow from this characterisation of the breach that Mr Condliff contends more specifically in this context that when considering whether his was an exceptional case under its IFR policy, the PCT was specifically obliged to have regard to A8 and in particular to any A8 factors which were invoked by him and which would not otherwise be considered. If there was no such obligation then the Social Factors Exclusion could not render the decision unlawful to the extent that it ruled out any such factors on the grounds that they were social

factors. Mr Clayton confirmed in oral argument that Mr Condliff did so contend. He accepted that if the decision-maker had said that he had in fact taken account of the A8 factors, balanced them against the other considerations and concluded that they did not lead to a conclusion of exceptionality, the decision was probably not susceptible of challenge. But there was no specific evidence that this had happened here.

The PCT's Position

34. The PCT accepted, as it was bound to do, that its decision not to treat Mr Condliff's case as exceptional had an impact on aspects of his private life including among other things his physical integrity in the sense that his position would be much improved if he could have the Surgery. That much would be true of any case where a PCT refused treatment of any significance to one who wanted it, whether by dint of the operation of a general policy (like the PCT's Primary Policy here) or by rejecting an IFR.

35. But Mr Lock for the PCT contends that it does not follow from this that A8 is engaged when a PCT considers an IFR in the sense that it is then positively obliged to have regard to any A8 factors invoked by the applicant insofar as they would not be considered anyway because clinically relevant. In the alternative Mr Lock contends that even if A8 was so engaged, the Social Factors Exclusion was, to the extent that it would rule out an A8 consideration, justified.

The Law – generally

36. I accept, as does the PCT, that I am obliged to take account of the jurisprudence of the European Court of Human Rights ("the Court") in considering whether it has acted in breach of Mr Condliff's A8 rights.

The Law - allocation of medical resources

37. I deal first with the cases concerned with A8 and the allocation of medical resources by a public authority like the PCT. In my judgment these are highly relevant to the present case even though Mr Condliff does not contend that there was a breach of his A8 rights simply because the Surgery was denied to him.

38. It is not in dispute that the delegated obligations imposed upon all PCTs by virtue of s3 of the National Health Service Act 2006 to provide medical services amount in general to target duties having regard to a PCT's obligation to break even each year (see s229 of the 2006 Act) and the fact that resources are limited. A PCT must therefore make choices about what treatments to fund and not to fund. See, for example, *R v North and East Devon Health Authority, Ex parte Coughlan* [2001] QB 213 at paras. 24-26. And provided that it acts rationally, a PCT may set policies allocating medical resources and treatments even though the effect thereof is that some people will be denied treatment from which they would undoubtedly benefit. As Lord Bingham said in *R v Cambridge Health Authority ex parte B* [1995] 1 WLR 898:

> "I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it costs, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet.... Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of

> the maximum number of patients. That is not a judgment which the court can make. In my judgment, it is not something that a health authority such as this authority can be fairly criticised for not advancing before the court."

39. It is not the role of the court to second-guess such decisions. Its role is generally limited to seeing that the decision-making is within the law. See *R (AC) v Berkshire West Primary Care Trust & Anor* [2011] EWCA Civ 247 per Hooper LJ at para. 56.

40. The general position of this PCT in relation to allocation of medical resources and the detailed steps it took in deciding and formulating its policy on bariatric surgery and in particular the threshold of showing a BMI of 50 or more, is set out in paragraphs 7 – 70 of Mr Warnes' first witness statement and in his second statement. As noted above there is no challenge to the PCT's Primary Policy here. It must therefore be assumed that the decision to adopt that Primary Policy was itself lawful (by reference to ECHR considerations and otherwise) even though its effect was to provide treatment to some who needed it, but not to others.

41. The UK Courts have consistently held that generally A8 is not engaged when a decision is made to allocate medical resources. In the Court of Appeal case of *R v North West Lancashire Health Authority ex parte A* [2000] 1 WLR 977 Auld LJ said at 995G:

> "In any event, article 8 imposes no positive obligations to provide treatment. The E.C.H.R. in Sheffield and Horsham v. United Kingdom (1998) 27 E.H.R.R. 163, which concerned post-operative refusal to accord legal status as a woman, said, at p. 191, para. 52:
>
> > "The court reiterates that the notion of 'respect' is not clear-cut, especially as far as the positive obligations inherent in that concept are concerned: having regard to the diversity of the practices followed and the situation obtaining in the contracting states, the notion's requirements will vary considerably from case to case. In determining whether or not a positive obligation exists, regard must be had to the fair balance that has to be struck between the general interest of the community and the interests of the individual, the search for which balance is inherent in the whole of the Convention."

and Buxton LJ said (at 1001D-E):

> "The ECHR jurisprudence demonstrates that a state can be guilty of such interference simply by inaction, though the cases in which that has been found do not seem to go beyond an obligation to adopt measures to prevent serious infractions of private or family life by subjects of the state: see X and Y v Netherlands 8 EHRR 235[93] and, more generally, Harris et al., Law of the European Convention on Human Rights (1995), pp 320-324. Such an interference could hardly be founded on a refusal to fund medical treatment. And in any event this case plainly falls under the reiterated guidance given by the Strasbourg Court in Cossey v United Kingdom (1990) 13 EHRR 622[37] and Sheffield and Horsham v United Kingdom (1998) 27 EHRR 163[52]"

42. Mr Clayton invites me to disregard this case first because the remarks of their Lordships were strictly *obiter* and secondly because this case was decided before the Human Rights Act came into force (though after it had been passed). I agree that I am not strictly bound because of the first reason but as to the second the Court dealt fully with the A8 point and Buxton LJ made clear (at p1000F-G) that if there was a legitimate complaint about a breach of the ECHR the Court of Appeal would take it extremely seriously. In my judgment I should accord considerable weight to this decision.

43. It has been cited in later first instance decisions, too. In *R (on the application of) v West Middlesex University Hospital NHS Trust* [2008] EWHC 855 (Admin) Mitting J said at para. 31:

"Article 8 of the Convention does not impose on a Convention state the obligation to provide medical treatment at any specific level to persons within its territory (see *Tysiac v Poland* 5410/03, 20th March 2007, paragraph 107). That statement of principle by the Strasbourg Court finds a clear echo in the decision of the House of Lords in *N v Secretary of State for the Home Department* [2005] 2 AC 296. By providing treatment to deal with life-threatening emergencies and situations in which serious injury may result if the patient is untreated, the state is fulfilling its minimum obligation under Article 8 and, if it still exists, under the law of common humanity"

44. And in another medical allocation case, *R (AC) v Berkshire West Primary Care Trust* [2010] EWHC 1162 (Admin) Bean J said at para. 37:

"In the *North West Lancashire* case Auld and Buxton LJJ were dismissive of arguments based on the European Convention on Human Rights. Since then, as Ms. Harrison points out, the Human Rights Act 1998 has come into force, and the Court at Strasbourg has given the important decision in *Goodwin v UK* (2002) 35 EHRR 18 overturning its previous jurisprudence on transsexuals. But Auld LJ's observation that Article 8 of the ECHR imposes no positive obligation to provide treatment is still good law: see *per* Mitting J in *A v West Middlesex University Hospital NHS Trust* [2008] EWHC 855 at paragraph 31. Even in combination with Article 14, Article 8 does not in my view add to Ms. Harrison's arguments"

45. I agree that Mr Justice Bean was there dealing with a different claim – by a transsexual to breast augmentation surgery. But his endorsement of *North West Lancashire* is not qualified in any way.

46. This decision was the subject of an unsuccessful appeal to the Court of Appeal (see the reference in paragraph 39 above) which challenged among other things para 37 of the judgment below. But the PCT was not called upon to respond on that point. That cannot amount to a positive approval by the Court of Appeal of *North West Lancashire*. But nor does it indicate any significant concern with it.

47. Finally, in *R (T & Ors)v London Borough of Haringey* [2005] EWHC 2235 (Admin) Ouseley J considered whether a positive duty arose on the PCT to provide the nursing care by virtue of Articles 2, 3 and 8 of the ECHR where a patient sought additional respite care. He held that it did not and said at paras. 135 and 142:

"As for Article 8 and Article 2 Protocol 1, whilst I accept that they could be engaged both for the mother, in her social and personal life, and D, in her personal, social and educational development, I do not consider that the level of nursing care provided breaches the qualified rights in Article 8 or, yet, the right to education. Both *Sentges* and *Pantiacova* show the wide margin of discretion afforded to states; the NHS Act target duties reflect that. They embody a wide margin for the judgment of statutory bodies charged with the allocation of resources to competing priorities, many of which could be said to engage Article 8(1). Both were admissibility decisions rejecting the existence of even an arguable claim"

and

"I accept that the ECHR obligations may cause a target duty to crystallise into a specific duty, or indeed create duties directly, but very considerable caution is needed before holding that to have happened in any individual case, as the authorities cited by Mr Bowen and the North West Lancashire Health Authority case show."

48. As for the decisions of the European Court, in *Sentges v. The Netherlands* (Application no 27677/02) the Court said that while the essential object of Article 8 was to protect the individual from arbitrary interference by the public authorities there may be positive obligations inherent in respect for private or family life and that A8 may impose such obligations on a state where there was a direct and immediate link between the measures the state was urged to take and the individual's private life. However,

"The Court has also held that Article 8 cannot be considered applicable each time an individual's everyday life is disrupted, but only in exceptional cases where the State's failure to adopt measures

> interferes with the individual's right to personal development and his or her right to establish and maintain relations with other human beings and the outside world. It is incumbent on the individual concerned to demonstrate the existence of a special link between the situation complained of and the particular needs of his or her private life....
> Even assuming that in the present case such a special link indeed exists... regard must be had to the fair balance that has to be struck between the competing interests of the individual and of the community as a whole and to the wide margin of appreciation enjoyed by States in this respect in determining the steps to be taken to ensure compliance with the Convention ....This margin of appreciation is even wider when, as in the present case, the issues involve an assessment of the priorities in the context of the allocation of limited State resources... In view of the familiarity with the demands made on the health care system as well as with the funds available to meet those demands, the national authorities are in a better position to carry out this assessment than an international court"

49. In that case the court rejected the admissibility of an A8 claim to a robotic arm from the claimant's insurers whose decision to refuse it was upheld by the domestic appeals court.

50. In *Pentiacova v Moldova* (Application No.14462/03: 4 January 2005) (2005) 40 E.H.R.R. SE23 the applicants suffered from chronic renal failure, needing haemodialysis, and complained about the State's failure to provide all the medication necessary for haemodialysis at public cost. The Court said that:

> "Although the object of Art.8 is essentially that of protecting the individual against arbitrary interference by the public authorities, it does not merely compel the State to abstain from such interference since it may also give rise to positive obligations inherent in effective "respect" for private and family life. While the boundaries between the State's positive and negative obligations under this provision do not always lend themselves to precise definition, the applicable principles are similar. In both contexts regard must be had to the fair balance that has to be struck between the competing interests of the individual and the community as a whole, and in both contexts the State enjoys a certain margin of appreciation."

51. While the Court said that A8 was relevant it held as it had in *Sentges* that the margin of appreciation was even wider than usual where what was involved was the allocation of medical resources and it rejected the complaint as inadmissible.

52. In my judgment the clear thrust of the cases referred to above is that generally speaking when a state's public body (like a PCT) decides how to allocate its medical resources among those who seek them A8 is not engaged. From the perspective of the Court it has a wide margin of appreciation (in the domestic context to be equated to a "wide area of discretionary judgment") in such an exercise. A refusal to fund treatment to an applicant is not an interference with his A8 rights in breach of A8 (1) nor is there any positive obligation to provide it.

53. In paragraph 34 of his Skeleton Argument, Mr Clayton submits that "It is therefore plain that the adverse effects of withholding medical treatment breach the Claimant's right of respect for private life and right of respect for the family contrary to Article 8(1)." That was said in the light of the decision of the Court in *Pretty v UK* to the effect that A8 included the right to die with dignity and to avoid further suffering, and therefore if the state prevented by law the exercise of that right (in that Mrs Pretty's husband would be committing the offence of assisting suicide) there was a breach. I see that, but *Pretty* was a case of interference, not breach of some positive obligation. While failing to provide treatment will have an impact on the quality of life and physical integrity of the person denied it, that does not, without more, amount to a breach of his A8 right on the part of the public authority so that justification is required.

54. Accordingly, when a PCT makes a policy decision about where to allocate its limited medical resources, assuming it does so on a rational basis, the A8 rights of any particular person who may be denied treatment as a result of a decision which applies that policy need not be considered by reason of some positive duty. If that be so, it is hard to see why the position should be any different when the PCT is considering an individual's application under an IFR.

A positive obligation in the context of the IFR?

55. However, Mr Clayton contends for a positive obligation upon the state to create a framework for the PCT within which its IFR decisions should take account of the individual's A8 rights (over and above A8 factors which are also clinical factors which will be considered anyway). As noted above, he contends in paragraph 38 of his skeleton argument that "the PCT.. [has a] positive obligation to put in place a regulatory framework of adjudicatory and enforcement machinery in place to safeguard the Claimant's Article 8 rights", so that the Social Factors Exclusion is a breach of that obligation.

56. The absence of any A8 engagement in the prior general policy decision process is a powerful factor militating against a positive duty to consider A8 rights in the IFR context. Mr Clayton says that there is no case which expressly says that and of course he is right. But on the other hand there is no case directly supporting the existence of the positive obligation for which he contends in the IFR context. That is not necessarily fatal if it could be established clearly that such an obligation arises as a matter of principle.

57. Here it is necessary to examine the ECHR cases relied upon in support of the alleged positive duty. In *Tysiac v Poland* (2007) 22 BHRC 155 the state permitted therapeutic abortions as an exception to the usual rule against abortions. Certain conditions had to be fulfilled but in practice the machinery to enable such abortions to be approved did not work so that the right of a qualifying woman to such an abortion was more apparent than real.

58. Having noted that the essential object of A8 was to prevent arbitrary interference by public authorities, the Court stated in paragraph 110 that

> "In addition, there may also be positive obligations inherent in an effective " respect" for private life. These obligations may involve the adoption of measures designed to secure respect for private life even in the sphere of relations between individuals, including both the provision of a regulatory framework of adjudicatory and enforcement machinery protecting individuals' rights and the implementation, where appropriate, of specific measures (see, among others, *X v Netherlands..)*"

59. In paragraph 111 the Courts stated much the same as it said in *Pentiacova* in the passage quoted in paragraph 50 above. In paragraph 112 it stated that:

> "The Court observes that the notion of " respect" is not clear-cut, especially as far as those positive obligations are concerned: having regard to the diversity of the practices followed and the situations obtaining in the contracting states, the notion's requirements will vary considerably from case to case. Nonetheless, for the assessment of positive obligations of the State it must be borne in mind that the rule of law, one of the fundamental principles of a democratic society, is inherent in all the Articles of the Convention."

And in paragraph 113 that:

> "...in the assessment of the present case it should be borne in mind that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective...Whilst Art.8 contains no explicit procedural requirements, it is important for the effective enjoyment of the rights guaranteed by this provision that the relevant decision-making process is fair and such as to afford due respect to the interests safeguarded by it. What has to be determined is whether, having regard to the particular circumstances of the case and notably the nature of the decisions to be taken, an individual has been involved in the decision-making process, seen as a whole, to a degree sufficient to provide her or him with the requisite protection of their interests..."

60. In the case before it, the Court went on to find that the state was regulating an area which touched the applicant's private life and there was a positive obligation to put in place a proper adjudicative framework to deal with where there was controversy as to whether she was entitled to a therapeutic abortion or not. See paragraphs 124 and 128 of the judgment. The important role of the rule of law was also emphasised. This was a case where it was necessary for the state to take further steps to ensure that a particular right which had been provided for and which was within A8 could properly be exercised. The later abortion case of *A, B & C v Ireland* [2010] ECHR 25579/05 was to the same effect.

61. As already noted, the Court in *Tysiac* referred to the earlier case of *X and Y v Netherlands* (1986) 8 EHHR 235 (as has the Court in other A8 cases) as the exemplar for the existence of a positive obligation to provide a "regulatory framework of adjudicatory and enforcement machinery protecting individual's rights and the implementation, where appropriate, of special measures." The problem in *X and Y* was that there appeared to be no effective criminal sanction under the law against a person who had committed rape against a mentally-handicapped victim because of the procedural requirements relating to the making of a complaint which could be satisfied neither by the victim nor by anyone else acting on her behalf. So there could be no prosecution. It was accepted that A8 applied because the relevant facts concerned the victim's private life. The Court held that the existing criminal law did not provide her with any practical or effective protection in an area where fundamental values and essential aspects of private life were at stake. There was a positive obligation on the state to have an effective enforcement system in place and as it did not, there was a breach. It should be noted that the procedural problem which stymied the prosecution had not been foreseen by the Dutch authorities. There was a substantive offence covering the wrong committed – it was just that it could not be proceeded with.

62. Both of these cases are very different from Mr Condliff's. I accept that in and of itself this does not mean that they are irrelevant. But the principle with which they were concerned needs to be properly understood. A framework was positively required so that recognised A8 rights could be properly adjudicated upon (*Tysiac)* or enforced (*X and Y*). Without it the relevant right was in jeopardy. But the case before me is not about a framework to safeguard A8 rights which is somehow missing. A8 rights are not, generally, engaged in healthcare resource allocation given the margin of appreciation afforded to states when they make such decisions. The IFR process is just one further aspect of such decision-making. So to talk of the need for a framework here to safeguard A8 rights simply makes no sense. The Court itself has emphasised on numerous occasions (including in *Tysiac* itself) that whether a positive obligation arises at all varies from case to case.

63. Indeed here the framework itself is not alleged to be missing. Mr Clayton says that the underlying framework is the whole of the NHS system. But if the workings of that system as far as medical resource rationing is concerned do not generally attract A8 then a restriction on (potentially) some non-clinical A8 factors cannot be said to be an unlawful interference

with or restriction upon or disruption of that system. There is no respect in which it is not working properly or failing to make its users' rights under A8 real rather than illusory. So it is not possible to assert a breach of A8 here by asserting the principle of having an effective system to safeguard A8 rights which is drawn from a very different context.

Fair balance and Justification

64. In my judgment, for the reasons set out above, the particular positive obligation contended for by Mr Condliff does not exist and so there can be no breach of A8 by reason of the Social Factors Exclusion. But insofar as is necessary, I would further justify that conclusion by saying that the Social Factors Exclusion, as part of the IFR policy, is itself a result of a fair balancing exercise which militates against the positive obligation. In the usual negative interference case, the fair balance to be struck between the competing interests of the individual and the community as a whole is part of the justification under A8 (2) if invoked. In the context of positive obligations the case-law generally sees fair balance as part of the determination as to whether the obligation exists at all. See the cases cited above.

65. In this regard it is necessary to consider the factors set out in the Appendix. See paragraph 10 above. By reference to the numbered paragraphs:

[1] It seems to me to be a legitimate point to say that for the PCT, essentially concerned with clinical matters, it will be difficult to make an objective assessment of individuals' differing non-clinical factors, even if not impossible; there is also the point made by Mr Lock that in this context it is not as if the PCT is then going to be able to investigate the credibility or otherwise of such claims;

[2] There is also force in the point that to make provision on the grounds of exceptionality taking into account social factors may be unfair to others who could show as good a case but who have been excluded. Mr Clayton says that this is a false point since the others could have applied themselves, but the point is valid when one recalls that the determination is one of exceptionality – that necessitates some sort of comparison with the excluded cohort. There is no great problem if this is confined to clinical matters because the PCT has sufficient knowledge available to it, but it could well be a problem if social factors were admissible;

[3] The avoidance of discrimination which could arise if social factors were included is also a fair concern;

[4] See [5] below;

[5] It also seems to me to be a fair consideration to follow the broad approach taken by the NHS. Mr Clayton says that this cannot justify a complete bar but in fact, it is hard to see how non-clinical social factors are to be treated other than by generally ruling them in or ruling them out. Any other policy would be very complex and time-consuming;

[6] Point 6 is largely the conclusion, not a reason, save that as a matter of common sense it would be surprising, if in considering medical resource allocation in this context, the emphasis was not on clinical matters. Here it is important to stress that the Social Factors Exclusion is not attacked, additionally, on the grounds that it is somehow irrational. It must therefore be treated as rational in its own terms.

66. There is the further point that if social factors were permitted there would be many more applications which would take longer to process with inevitable consequences for resources which would otherwise be available for others. See paragraph 78 of Mr Warnes' witness statement.

67. In my judgment it is impossible to see how the Social Factors Exclusion, as part of the PCT policy of medical resource allocation, does not amount to a fair balance between the individuals seeking treatment under the IFRs and the medical requirements of the community as a whole. And in relation to the approach of the Court to that question, the wide margin of appreciation would no doubt be factored in, as noted by Ouseley J in *T* – see paragraph 47 above.

68. Both Mr Clayton and Mr Lock addressed me on the question of proportionality generally. Both did so on the assumption that the positive obligation was found to exist and if so, the breach caused by the Social Factors Exclusion needed to be justified. For my own part I consider that the factors under A8 (2) fall more naturally within the question as to whether there was a positive obligation at all. Either way, however, and insofar as it is necessary to have regard to proportionality I now consider it.

69. As to legitimate aim there is a statutory duty on PCTs to break even and to allocate scarce resources on the footing that there are not enough to provide for everyone's medical requirements. In the context of providing for a limited exception to the Primary Policy of refusing bariatric surgery to those with BMIs of less than 50, not itself challenged, the Social Factors Exclusion is clearly rationally connected to that aim. It is required, for the reasons given by the PCT in the Appendix. As to whether it is no more than necessary, Mr Clayton says that it is too much of a blunt instrument because it is a blanket exclusion which cannot be justified – see for example *Hirst v UK No. 2* [2005] ECHR 74025, the prisoners' voting case, at paras. 77, 80 and 82. But this is a very different kind of exclusion and as already noted it is hard to see how a policy of this kind – which is designed to keep the exceptionality consideration to clinical matters – could be framed other than by excluding social factors generally. Mr Clayton says that the policies of other PCTs can be much less than a total exclusion – so that the Social Factors Exclusion here is not necessary. But for the reasons already given I doubt whether in reality there is much difference between this PCT's policy and that of the two others to which I was referred. Finally, I have dealt with fair balance in paragraphs 65- 67 above.

70. Accordingly, in my judgment, the Social Factors Exclusion does not violate A8 either because the claimed positive obligation never arose or because, if it did, it is then justified.

71. Mr Clayton then contends that this is not the end of the story because the object of challenge here - as it must be - is not simply the Social Factors Exclusion but the decision of 13 October 2010 directed to Mr Condliff. He says that there is no evidence that this decision was itself proportionate. I do not accept this argument. If the Social Factors Exclusion, as a policy, does not violate A8 (in other words there is no need to consider non-clinical social factors insofar as they would not be considered anyway and insofar as they touched upon A8 rights) I fail to see how any decision which applied it is subject to some yet further A8 scrutiny. There is no need to conduct some other A8 exercise at that point just as there is no need for such an exercise when a person is denied treatment on the basis that he simply fails to qualify under the Primary Policy.

72. Accordingly, I reject Ground 1.

GROUND 2 – FAILURE TO GIVE REASONS UNDER ARTICLE 6 (1)

73. Article 6(1) states:

> "In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgement shall be pronounced publicly by the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice."

74. Mr Condliff contends that if his civil rights were determined by the PCT he was impliedly entitled to adequate reasons for its conclusion. He then alleges (a) that his A8 rights are "civil rights" (b) that they were "determined" by the decision of 13 October but (c) the PCT gave no adequate reasons as to why it had in fact acted compatibly with A8.

75. In my judgment, if my primary analysis of the A8 position is correct, there is no scope for A6 to operate with reference to A8 because no A8 positive obligations arose at all. While I have in this judgment determined that A8 is not engaged, the PCT made no determination to that effect. If A8 is not engaged, the fact that the decision may have rejected some private life factors in reaching the conclusion that Mr Condliff's case was not exceptional, does not mean that it "determined" his A8 rights, assuming for present purposes that they constituted civil rights.

76. However, I consider the matter further lest that view be wrong or if the proper analysis of the PCT's success on Ground 1 is to say that A8 was engaged by means of a positive obligation but its breach occasioned by the Social Factors Exclusion was nonetheless justified.

77. According to Lord Nicholls in *Re S* [2002] 2 AC 291:

> "Although a right guaranteed by article 8 is not in itself a civil right within the meaning of article 6(1), the Human Rights Act has now transformed the position in this country. By virtue of the Human Rights Act article 8 rights are now part of the civil rights of parents and children for the purposes of article 6(1). This is because now, under section 6 of the Act, it is unlawful for a public authority to act inconsistently with article 8."

78. Mr Lock contends that this must now be read in the light of the decision of the Supreme Court in *Tomlinson v Birmingham City Council* [2010] UKSC 8. This held that an application for and refusal of, accommodation to a homeless person under Part VI of the Housing Act 1996 did not engage A6 because the right to claim such accommodation was not itself a civil right. This was because the whole process involved a series of evaluative judgments by the provider as to whether statutory criteria were met and how they should be satisfied. See in particular paras. 30, 39, 43 and 49 of the judgment. Had the matter not involved any assertion of A8 I would have had no hesitation in applying the same reasoning to the application and decision process involved in the IFR. The decision of the PCT was an administrative one, allocating or not allocating medical resources on the basis of evaluative judgments where there is no underlying "right" to any particular medical treatment, only a target duty on the PCT to provide it.

79. Does the fact that A8 rights are also invoked here make a difference? In my judgment it does not. I of course accept what Lord Nicholls says in *Re S*, noted above, but the context there was the fact that civil rights had to relate to domestic law, so that until "domesticated" by the HRA 1998, A8 could not possibly amount to a civil right. He was not considering the point from the perspective of the nature of the application and decision in question, as was the Supreme Court in *Tomlinson*. I therefore agree with Mr Lock that the decision in *Tomlinson* and nature of the process involved here (the possibility of Mr Condliff benefiting from an administrative decision of the PCT exercising its evaluative functions in the context of exceptionality) means that A6 (1) was not engaged, irrespective of whether there was or was not a positive obligation to consider any A8 factors invoked.

80. If I am wrong about that, there then arises the question whether there were adequate reasons given for considering that the decision did not violate A8 because it was justified.

81. Certainly one cannot find such reasons in the letter of 13 October 2010. But in my judgment this is the wrong place to look. The basis for the justification lies in the reasons for the Social Factors Exclusion given in the Appendix. As was accepted, this was a publicly available document and it was not suggested that Dr Linney was not aware of it. The justification was expanded somewhat by Mr Warnes and in argument before me but the essence was there in the document itself. For the reasons already given in paragraph 71 above, there was no further social factor A8 assessment when it came to making the decision. Adequate reasons were therefore given.

82. If I am wrong about that and there was, strictly, a breach of A6 (1), I would not here award any substantive remedy because the reasons are found in the Appendix and the evidence of Mr Warnes. Mr Condliff (or rather his legal advisers) have had no difficulty in formulating the challenge to this decision which, by the time the Grounds were served, included the specific challenge to the Social Factors Exclusion which was made under Ground 1.

83. Accordingly, my primary conclusion is that there was no breach of A6 but if there was, I would not award any substantive relief.

GROUND 3 – BREACH BY THE PCT OF ITS OWN IFR POLICY

84. As refined, the particular points now in issue are summarised in paragraph 68 (b) and (d) of Mr Clayton's skeleton argument as follows: the PCT

    (1) failed contrary to paragraph 5.1.2 and 5.1.3 of the IFR Policy to move the request for funding on to a Review of Requests under paragraph 5.2 as funding for bariatric surgery for patient of less than 50 BMI kg/m2 was not covered by an existing service level agreement but was subject to restricted funding; and

    (2) failed contrary to paragraph 5.2.1 to find that Dr. Linney's letter (taken together with the evidence already before the PCT from Mr. Laing, Professor Clayton, Professor Davies, Dr. Allen, Mrs. Teasdale, Mrs. Wilkins from March 2010) amounted to prima facie evidence of exceptionality in accordance with paragraph 5.2.1.."

85. In argument Mr Clayton did not lay any great stress on the first point, regarding it as tied in with an earlier complaint that the wrong person had dealt with the renewed IFR, a matter

resolved by the service of some further evidence. But the complaint may also have related to the fact that the renewed IFR was dealt with by Dr Harvey who effectively screened it to see if there was any fresh evidence which could potentially demonstrate exceptionality so as to warrant the case going back to a full IFR Panel. But I can see nothing wrong in this approach. When an initial IFR is made, this is also screened to see if there is *prima facie* evidence of exceptionality. There is no obvious breach of the policy committed because of how Dr Harvey dealt with the matter in October 2010 and it is not suggested that the process was irrational or unfair.

86. The second claim is really to the effect that no reasonable physician undertaking the task which Dr Harvey did could have concluded that there was no new *prima facie* evidence of exceptionality. In my judgment that is a hopeless submission. Dr Harvey has explained his clinical thought-processes in paragraphs 26 and 27 of his witness statement as set out in paragraph 28 above and, especially in the context of an exceptionality test which suggests that the number of successful applicants will be small and which is not itself challenged, this court will be very slow indeed to interfere. It should not do so here.

87. I therefore reject Ground 3.

GROUND 4 – LACK OF REASONS GENERALLY

88. Pursuant to powers granted by section 8(1)(2) of the 2006 Act, the Secretary of State issued the "Directions to Primary Care Trusts and NHS trusts concerning decisions about drugs and other treatments 2009". Direction 3(3) states that:

> Where a Primary Care Trust makes a decision to refuse a request for the funding of a health care intervention for an individual, where the Primary Care Trust's general policy is not to fund that intervention, the Primary Care Trust must provide that individual with a written statement of its reasons for that decision.

89. The PCT was thus obliged to give reasons for its decision of 13 October 2010 both as a result of that provision and pursuant to its common-law duty of fairness.

90. Mr Condliff contends that no or no adequate reasons were given for the decision which said simply that the public health consultant who reviewed the letter felt that there was no new evidence for the panel to consider and the additional information provided did not demonstrate exceptionality.

91. Mr Condliff cannot now, and does not, challenge the decision of 17 March 2010 rejecting his original IFR. In fact, both in relation to that decision and the decision in question, Mr Condliff invoked neither his right of appeal nor the complaints procedure. But it is necessary to go back to the March decision so that the later decision can be seen in context. On 11 March Mr Condliff's application was considered by the full panel. It concluded that he did not meet any of the three exceptionality criteria which were required, as set out in paragraph 8 above, and which are not themselves challenged. The reasons were brief because they were showing a negative – a failure to meet the particular exceptionality points. In relation to criterion 1 (that he was not part of some definable group however small) the decision letter said that there was a definable group of patients with morbid obesity and co-morbidities. It was said by Mr Clayton that this was unsatisfactory because the size of this

cohort was not stated but I would not have seen that as rendering the reasons inadequate especially given that the group could be "small".

92. When it came to the October decision made after further information was submitted there was no real explanation given as to why it did not amount to anything new. I consider that more than this was required especially given that Mr Condliff was making a further application and needed at least some kind of steer as to what might or might not prove acceptable in the future. The essence of the PCT's thinking has only appeared in paragraphs 26 and 27 Dr Harvey's witness statement, summarised in paragraph 28 above.

93. It is of course possible for a Defendant to rely upon reasons for a decision not articulated at the time with a view to asking the court not to quash it. In this regard I was referred to the case of *R v City of Westminster Ex p Ermakov* [1995] EWCA Civ 42. This was concerned with a statutory obligation on a local authority to give reasons when declaring that a person was intentionally homeless. In that case the wrong reasons were given at the time and the true reasons were not disclosed. They only appeared later in an affidavit in the judicial review claim. The Court of Appeal reversed the decision of the Judge to dismiss the claim notwithstanding this, on the basis that the matter should be remitted for reconsideration because the only reasons given for the decision were defective in that they were not the true reasons and were not relied upon. In the course of his judgment Lord Justice Hutchison stated as follows:

> "(2)...The court can and, in appropriate cases, should admit evidence to elucidate or, exceptionally, correct or add to the reasons; but should.. be very cautious about doing so.... the function of such evidence should generally be elucidation not fundamental alteration. Certainly there seems to me to be no warrant for receiving and relying on as validating the decision evidence - as in this case – which indicates that the real reasons were wholly different from the stated reasons....in this class of case, I do not consider that it is necessary for the applicant to show prejudice before he can obtain relief. Section 64 requires a decision and at the same time reasons; and if no reasons (which is the reality of a case such as the present) or wholly deficient reasons are given, he is prima facie entitled to have the decision quashed as unlawful.
> (3) ..The cases emphasise that the purpose of reasons is to inform the parties why they have won or lost and enable them to assess whether they have any ground for challenging an adverse decision. To permit wholesale amendment or reversal of the stated reasons is inimical to this purpose... in many cases it might be, suggested that the alleged true reasons were in fact second thoughts designed to remedy an otherwise fatal error exposed by the judicial review proceedings. That would lead to applications to cross-examine and possibly for further discovery.. both of which are.. generally regarded as inappropriate...
> (4) While it is true.. that judicial review is a discretionary remedy and that relief may be refused in cases where, even though the ground of challenge is made good, it is clear that on reconsideration the decision would be the same, I agree .. that, in cases where the reasons stated in the decision letter have been shown to be manifestly flawed, it should only be in very exceptional cases that relief should be refused on the strength of reasons adduced in evidence after the commencement of proceedings.. ..I also wish to emphasise that all that I have said is with reference only to the provisions of section 64 of the Housing Act 1985."

94. In this case, there is no question of contradictory reasons being given. Rather the given reason is very truncated. The core reasoning behind the conclusion that there was nothing new did not appear in the letter at all. It only appears in Dr Harvey's witness statement. As to that it is said that I should not admit it for these purposes at all. I reject that. I see no basis for saying that Dr Harvey's recollection is likely to be defective even though the witness statement came something over 4 months after the decision. In truth his was a short and simple clinical point. Nor is it suggested that it is implausible. He did make some other

comments in his paragraph 26 about bariatric surgery not being the only solution and that it was not a panacea but these were clearly not the key reasons why he regarded the further information as not being new – this was because the information showed a worsening of the existing clinical conditions which in his view did not make his case (now) exceptional. Mr Telford submitted that Dr Harvey's reference to para. 5.5.3 of the IFR policy must have been mistaken because he was not acting as the panel but only to screen the information. But Dr Harvey never suggested he was the panel. He correctly stated that he was assessing the information to see if there was enough to form a new case of exceptionality to go to the panel.

95. The real question is whether, given that the reasons have now been given, I should quash the decision on Ground 4. Here I take into account the fact that it was open to Mr Condliff following the decision in October (and indeed in March) 2010 to ask for clarification about the decision and for an explanation as to why the further information was not new. He could have done so at any time and could if necessary have invoked the complaints procedure. Indeed, of the many grounds of challenge enunciated in the letter before action of 15 November 2010, lack of reasons is not one of them. I cannot see that any useful purpose is served in remitting the decision for reconsideration simply so that the PCT can give the reasons already given by Dr Harvey which I do not consider to be themselves inadequate. As I have said his point is a short one.

96. Accordingly although there was a breach of the duty to give reasons, I would not quash the decision on that ground.

97. It was also said as part of Ground 4 that the paucity of reasons means that the decision itself should be regarded as irrational. I reject that contention also. The evidence of Dr Harvey shows that it was not irrational.

CONCLUSION

98. I have very considerable sympathy for Mr Condliff and the unfortunate and serious condition in which he finds himself. But for all the reasons given above I have to conclude that his claim for judicial review must fail.

99. In the course of the hearing, some updating evidence about Mr Condliff was produced. I have not referred to it above because it was not relevant to my considerations. But I should record that Mr Lock very fairly pointed out that it remains open to Mr Condliff to make a yet further IFR, if thought appropriate, which can be dealt with swiftly by the PCT.

100. I am most grateful to Counsel for their excellent oral and written submissions.