



Neutral Citation Number: [2021] EWHC 2175 (Admin)

Case No: CO/3345/2019

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30/07/2021

Before :

THE HON. MR JUSTICE BOURNE

Between :

THE QUEEN on the application of

CSM

Claimant

- and -

**SECRETARY OF STATE FOR THE HOME
DEPARTMENT**

Defendant

Chris Buttler QC and Raza Halim (instructed by Duncan Lewis) for the Claimant
Zane Malik QC (instructed by Government Legal Department) for the Defendant

Hearing dates: 23-24 June 2021

Approved Judgment

The Hon Mr Justice Bourne:

Introduction

1. The Claimant is a national of the Democratic Republic of Congo (“DRC”) who was held in immigration detention in August 2019.
2. The Claimant first arrived in the UK in 1996 aged 4. His father was granted refugee status, which led to his being given indefinite leave to remain in the UK from 28 November 2002.
3. As a child the Claimant contracted HIV. He requires daily antiretroviral medications for life.
4. In 2013 the Claimant pleaded guilty to charges of attempted robbery and possession of a firearm and ammunition and was sentenced to 7 years and 2 months in prison.
5. Those convictions led to the Claimant being deported to DRC on 17 October 2017. He claims that on arrival in DRC he was detained, interrogated and tortured. At some point in 2018 he managed to make his way back to the UK. Thereafter he first came to the Defendant’s attention on 5 August 2019 when he made an asylum claim based on his ill-treatment in DRC. That claim remains outstanding.
6. The Claimant attended an asylum screening interview on 8 August 2019, whereupon he was detained from then until 30 August 2019.
7. By his 7 grounds of judicial review the Claimant alleges that the Defendant (by her officials):
 - i) infringed his rights under Article 3 of the European Convention on Human Rights (ECHR) by failing to take reasonable steps to provide him with the necessary medication in detention until the evening of 11 August 2019 and by failing to put in place an effective framework for the protection of detainees with HIV;
 - ii) contrary to the requirements of rule 34 of the Detention Centre Rules 2001 (SI 2001/238), failed to ask the Claimant whether he was a victim of torture and thereby failed to apply the Defendant’s Adults at Risk policy (“AARP”) in deciding to keep him in detention;
 - iii) failed within a reasonable time to produce, and respond to, a report on the Claimant’s vulnerability under rule 35 of the Detention Centre Rules 2001 and thereby failed to apply the AARP;
 - iv) failed to comply with the AARP by addressing evidence that the Claimant was a victim of torture;
 - v) held the Claimant for two days at a short-term holding facility (“STHF”) and failed to make reports on the risks to his health and the evidence that he was a torture victim, contrary to rules 6, 32 and 33 of the Defendant’s STHF Rules;

- vi) decided to detain him without addressing his allegations of torture, his vulnerability due to HIV and the lack of a prospect of removing him to DRC within a reasonable time; and
 - vii) detained him contrary to principles 1, 2 and 3 as stated in *R v Governor of Durham Prison ex p Hardial Singh* [1984] 1 All ER 983.
8. These grounds gave rise to a number of disputes of fact. With the agreement of the parties, the Court has taken the unusual step in a judicial review of hearing oral evidence from three of the Defendant's witnesses and the Claimant himself.
9. At the hearing, the grounds were condensed into three overarching issues:
- i) Was there a systemic flaw in the Defendant's arrangements for detention of individuals with HIV, in breach of the positive obligation under Article 3 ECHR referred to as the "systems duty"?
 - ii) In her treatment of the Claimant, did the Defendant breach the positive obligation under Article 3 referred to as the "operational duty"?
 - iii) Was the Claimant falsely imprisoned by the Defendant?

Legal framework

10. Article 3 of the ECHR provides:
- "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."
11. In summary, Article 3 requires the State to put in place appropriate legal and administrative systems for protecting those who are vulnerable to treatment which would contravene it (the "systems duty") and to take appropriate steps if it becomes aware that a person is at a real and immediate risk of suffering such treatment (the "operational duty"). These duties are discussed in more detail below.
12. Immigration legislation provides various powers under which individuals may be detained on the authority of the Defendant.
13. In particular, paragraph 16(2) of Schedule 2 to the Immigration Act 1971 provides that if there are reasonable grounds for suspecting that a person is someone in respect of whom directions for removal from the UK may be given under any of various provisions of that Act, that person may be detained under the authority of an immigration officer pending a decision on whether to remove and pending removal.
14. Case law has recognised a number of restraints on the Defendant's immigration detention powers. Four important principles were set out in *R v Governor of Durham Prison, Ex p Hardial Singh* [1984] 1 WLR 704, as summarised and explained by the Supreme Court in *Lumba v Secretary of State for the Home Department* [2011] UKSC 12 [2012] 1 AC 245:
- i) The Secretary of State must intend to remove the individual and can only use the power to detain for that purpose.

- ii) The individual 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 the removal within that reasonable period, she should not seek to exercise the power of detention.
 - iv) The Secretary of State should act with reasonable diligence and expedition to effect removal of a person in detention.
15. The statutory powers confer a discretion on the Defendant, which is exercised in practice by her officials such as immigration officers. The Defendant maintains published policies on how the discretion is to be exercised in practice. Some of these are found in secondary legislation. That legislation is binding, and ordinary public law principles also require the Defendant to follow her stated policy unless she has a good reason to depart from it.
16. The Supreme Court in *Lumba* ruled that if, when making a decision to detain, the decision maker makes an error of public law which is material, i.e. an error which bears on the decision to detain, the detention will be unlawful and will amount to the tort of false imprisonment. However, whilst a Claimant will usually be entitled to a declaration if such unlawfulness is made out, he will be entitled only to nominal damages – and not to compensatory damages – if it is proved that detention would have occurred even if the public law error had not been committed.

Policy framework

17. The Defendant’s published guidance includes *Adults at risk in immigration detention* (the policy referred to as “AARP”)¹. Its introduction states:
- “In all cases in which an individual is being considered for immigration detention in order to facilitate their removal, an assessment must first be made of whether the individual is an ‘adult at risk’ in the terms of this policy and, if so, the level of evidence (based on the available evidence, which may be limited to the individual’s account) indicating the level of the policy into which they fall. If the individual is considered to be at risk, a further assessment will be made of whether the immigration considerations outweigh any risk identified. Only when they do will the individual be detained.”
18. Under the AARP guidance, an adult will be regarded as being at risk if, for example, they declare that they are suffering from a condition “that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention”. Consideration is required to be given to whether a medical condition can be managed in detention e.g. with medication, and decision makers are required to ask, among other things, “what happens if they do not take their medication”. The guidance requires decision makers to assess and balance risk factors and immigration control factors (such as the possibility that the individual will abscond and/or commit offences)

¹ At the material time the applicable edition was version 5.0, 6 March 2019.

and to place the case in one of three levels. As will be seen, this case was assessed at level 2, meaning:

“Where there is professional and/or official documentary evidence indicating that an individual is an adult at risk but no indication that detention is likely to lead to a significant risk of harm to the individual if detained for the period identified as necessary to effect removal, they should be considered for detention only if one of the following applies:

- the date of removal is fixed, or can be fixed quickly, and is within a reasonable timescale and the individual has failed to comply with reasonable voluntary return opportunities, or if the individual is being detained at the border pending removal having been refused entry to the UK
- they present a level of public protection concerns that would justify detention, for example, if they meet the criteria of foreign criminal as defined in the Immigration Act 2014 or there is a relevant national security or other public protection concern
- there are negative indicators of non-compliance which suggest that the individual is highly likely not to be removable unless detained

Less compelling evidence of non-compliance should be taken into account if there are also public protection issues. The combination of such non-compliance and public protection issues may justify detention in these cases.”

19. The AARP does not contain any information or guidance specifically about detainees with HIV.
20. The Defendant called evidence from Emily Jarvis, a Senior Executive Officer. She is one of a number of officials who discharge a function referred to as the Detention Gatekeeper (“DGK”), and gave me some information about that function.
21. The DGK function was introduced in 2016, though I have not been shown any published policy document relating to it. It was introduced in response to a review into the welfare of vulnerable persons in detention which was conducted for the Home Office by Stephen Shaw, who reported in January 2016. He recommended the putting in place of a single “gatekeeper” who would ensure consistent application of the policy on persons considered unsuitable for detention, ensure that vulnerable individuals are not detained, carry out risk assessments and “maintain strategic oversight of the population mix”. In a follow-up report in July 2018, he noted that the Home Office considered the new function to be working well, but expressed the view that the policy did not yet seem to be delivering the expected outcome in terms of the number of vulnerable people in detention.

22. Ms Jarvis stated that approval must be obtained from the DGK “for each and every occasion a person is detained under statutory immigration powers”. Front line officials such as those at Kent Intake Unit, Dover (“KIU”) are required to submit a referral form, providing all the relevant information including information about health and vulnerability issues. Every referral is assessed individually, applying relevant policy including the AARP. As she put it: “The DGK will determine whether approval to detain is to be granted or not.”
23. In this and many other cases, an individual may initially be detained in a place referred to as a short-term holding facility (“STHF”) before later being transferred to a removal centre where longer-term detention may take place. The use of STHFs is governed by the Short-term Holding Facility Rules (SI 2018/409, the “STHFR”).
24. Rule 2 of the STHFR defines a “holding room” as “a short-term holding facility where a detained person may be detained for a period of not more than 24 hours unless a longer period is authorised by the Secretary of State. Rule 6 further provides:
- “(1) Subject to paragraph (2), a detained person must not be detained in a holding room for a period of more than 24 hours.
- (2) The Secretary of State may authorise this period to be extended if the Secretary of State determines that exceptional circumstances require it.”
25. The Defendant published a policy document entitled *Short-term Holding Facility Rules 2018* (version 1.0) on 2 July 2018. It states that authority to detain in a STHF for over 24 hours must be obtained before the 24 hour point is reached from an officer of at least Senior Officer or SEO level, in person if possible or otherwise by telephone. The guidance continues:
- “The request for authority and the grant, or refusal, of authorisation must be recorded on the Case Information Database (CID) and the port file. This must include all the following:
- the time the person was initially detained
 - the time of the authorisation request and the time of the authorisation (or refusal) decision
 - the reason for extending (or refusing to extend) the period of detention
- Where an extension of stay in a holding room is authorised the record must also include both:
- the name of the person who has authorised the extension with their grade
 - the period of time for which the extension was authorised

Where authority to extend a detainee's stay in a holding room is given it is important that authority must be given for a specific period of time. It must not be open-ended.

It should be for no longer than is considered reasonably necessary to deal with the particular exceptional circumstances which gave rise to the need to extend the stay in the holding room in the first place. This initial authority must not exceed 12 hours.”

26. Further provision about immigration detention is made by the Detention Centre Rules (SI 2001/238). Of significance in the present case are rules 34 and 35:

“34.— Medical examination upon admission and thereafter

(1) Every detained person shall be given a physical and mental examination by the medical practitioner (or another registered medical practitioner in accordance with rules 33(7) or (10)) within 24 hours of his admission to the detention centre.

(2) Nothing in paragraph (1) shall allow an examination to be given in any case where the detained person does not consent to it.

(3) If a detained person does not consent to an examination under paragraph (1), he shall be entitled to the examination at any subsequent time upon request.

35.— Special illnesses and conditions (including torture claims)

(1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.

...

(3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.

(4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.

(5) The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for his supervision or care.

...”

27. The Defendant’s Detention Services Order 09/2016, p.16, provides that her officials must respond to a rule 35 report “as soon as possible but no later than the end of the second working day after the day of receipt”.
28. It does not appear that the Defendant has published any policy specifically applicable to detainees who are infected with HIV.
29. However, in March 2019 the British HIV Association and the National Aids Trust (“BHIVA” and “NAT”) published a guidance document entitled *Immigration detention and HIV: Advice for healthcare and operational staff*. Its authors acknowledged receipt of advice and information from a number of individuals including two of the Defendant’s officers. Its foreword states:

“This guide brings together current Home Office rules and guidance, with guidelines on HIV prevention, treatment and care, and relevant wider healthcare standards. It provides the information and advice that will enable staff in Immigration Removal Centres, Short-term Holding Facilities and HIV services to meet their obligations and ensure that people living with HIV in immigration detention receive the best possible treatment and care.”
30. Section 2.1.1 of the guidance states:

“HIV medication, or ART, offers lifesaving treatment, but some people who have been prescribed ART can find the regimen demanding and many require support to maintain good adherence.
31. The guidance explains that drugs must be taken at the same time every day, according to specific instructions. Some ART drugs must be taken with food, others at night before going to bed. At least 95% adherence to treatment is required. This means missing no more than one dose a month for someone taking once-daily therapy, or two doses a month with twice-daily therapy. Missed doses compromise the efficacy of therapy and can lead to drug resistance which limits future treatment options.
32. The relationship between this guidance and the Defendant’s policy is considered further below.
33. Detention in cases involving nationals of the DRC was affected by a specific policy development. On an unspecified date in June 2019, the Home Office issued an “interim operational instruction” imposing a temporary pause on returns to DRC (“the IOI”). It stated the following:

“Instruction to staff:

With immediate effect and until further notice, staff should refrain from pursuing the detention and enforced return of DRC

nationals. For those wishing to take a voluntary return, please ensure they are referred to the Voluntary Returns Scheme (VRS).

Undocumented cases may still be referred for a re-documentation interview via the DRC interview scheme process. Interviews will continue to be conducted at immigration reporting centres, immigration removal centres and Her Majesty's Prisons.

Background:

We have recently received a report, Unsafe Return 3, which documents a number of allegations of DRC nationals returned from the UK who experienced problems, including detention and ill-treatment, on or shortly after return between 2012 and 2018.

The Country Policy and Information Team has withdrawn the country policy and information note (CPIN) on unsuccessful asylum seekers and foreign national offenders while it reviews the information in Unsafe Return 3 and the current country situation in the DRC.

Upon completion of the review, an updated CPIN and a revised instruction will be issued accordingly.

Director clearance: Yes

Name: [redacted]

Expiry date: 31 August 2019".

The facts

34. I have already summarised the facts leading up to the Claimant's asylum application.
35. The facts of what happened after the Claimant attended for his asylum screening interview at KIU have emerged piecemeal. I shall consider, first, the facts about his initial care and treatment by the Defendant's officials; second, the decisions made by officials in respect of his detention; and third, the later developments.

Initial care and treatment

36. The Defendant's efforts to obtain and disclose all relevant documentation were not very satisfactory. A number of screenshots from the computer system containing healthcare records from the immigration removal centre ("IRC") at Harmondsworth were disclosed on the evening of 21 June 2021, effectively one working day before the hearing. On the first day of the hearing, one of the Defendant's witnesses said in cross-examination that there would be information about, for example, the food offered to the Defendant at KIU, in records kept by the Mitie Group plc, an independent contractor

which provides care and custody services there. That evening, half way through the hearing, those records were disclosed.

37. Greater care needs to be taken in the preparation of cases like this. At an early stage, the Defendant's lawyers should explore and analyse the case with input from their witnesses, a process which should enable them to identify and obtain all relevant documents including those held by contractors.
38. Unfortunately the Claimant's evidence, explored in cross-examination, was also unsatisfactory, as I shall explain.
39. In two witness statements the Claimant describes attending for his asylum screening interview at KIU on the morning of Thursday 8 August 2019.
40. The earlier statement says that he was invited to attend between 0800 and 1400, whilst the later one says the appointment was 0800-1100. That later statement says that he had last taken his medication, which he usually took with breakfast, at 10 o'clock the previous morning, 7 August, and continues: "Because the appointment was so early, I thought that I would be able to take my medication when I returned home, with some food, instead of taking it so early before I left for my appointment."
41. In the witness box the Claimant said that he left London (having travelled from his home in Stoke the previous day) at 0800 and that it took 3 hours to get to KIU because of traffic. That makes his rationale for not bringing his medication very hard to follow, even before one considers the contradiction between the two statements about the timing of the interview invitation. I bear in mind that he has previous experience of the system, having been detained and deported in 2017. Before contacting the Home Office in 2019 he took legal advice and he was represented by his current solicitors when he made his asylum application. Having returned to the UK in breach of a deportation order, he cannot have been surprised to face at least the possibility of detention when he first encountered the Defendant's officials on 8 August 2019.
42. He described the interview as brief, lasting no more than 10 minutes. However, the records disclosed by the Defendant indicate that it lasted about 45 minutes.
43. After the interview, staff told him that he would be transferred to the immigration removal centre ("IRC") at Harmondsworth (where he had been detained in 2017), but that they could not take him there unless he had his HIV medication with him. He described staff taking him first to a pharmacy to try to obtain medication, and that evening to a local hospital, but without success. He says that he was then kept in a crowded waiting room at the Intake Unit for 36 hours, sleeping on the floor and without being given any hot food.
44. The Mitie records which were disclosed during the hearing indicate that in fact he was given hot food. His oral evidence was also rather confused about the seating and sleeping arrangements in the room.
45. The Defendant relies on the written and oral evidence of Terence Lavelle, a Chief Immigration Officer who was on duty on 8 August 2019. Mr Lavelle said that the Claimant was expected to have brought medication with him in view of his previous history, and also that at his screening he confirmed having taken that day's dose.

46. I have seen a KIU booking-in form which records the Claimant's 2002 HIV diagnosis, lists the medications and the dose and just states "no meds". The decision on whether to keep him in detention was referred to the DGK. That referral was sent by email by another CIO at 15.46 on 8 August, and the email states: "We have detained him, however, he does not have his meds with him, but has taken today's medication". Also, the record of the screening interview refers to the medication and states "taken today".
47. In my judgment the Claimant is an unreliable witness whose evidence on several points of detail was contradicted by contemporaneous records. On the basis of the documents, I find on the balance of probabilities that he did take his medication on the morning of 8 August 2019 before travelling to KIU (a conclusion bolstered by the illogicality of his explanation for not taking it) and that he told officials this in the screening interview.
48. Records show that on the evening of 8 August 2019, KIU were in telephone contact with the NHS 111 telephone service, and that a doctor was expected to call back "to discuss issuing a prescription so we can place him into detention". The doctor called back at 0515 on 9 August and gave what proved to be unsound advice to seek the prescription from a local sexual health clinic.
49. Later on 9 August, Mr Lavelle recorded that contact had been made with the Claimant's treating consultant, Dr Rosenvinge, and arrangements had finally been made for the medication to be collected that day. As his statement explains, he spoke both to Dr Rosenvinge and to the Claimant about it.
50. The Claimant said that at about 1100 on 9 August, he was placed on a telephone call to his treating doctor, Dr Rosenvinge, at the Alexis Clinic in Lewisham. She advised him that not taking his medication was very dangerous and advised him to let her issue a prescription for him, and he agreed. He had not previously agreed because he did not like the way that he was treated at KIU and did not trust the officials.
51. At around 2000 on 9 August, the Claimant's medication arrived from Lewisham. He was then transferred to the IRC at Harmondsworth, arriving at about midnight. There he was seen by a male nurse, whom he knew from his detention in 2017. The Claimant said that the nurse asked about the medication and when he had last taken it. He said that he did not want to keep it with him because other detainees might pry into what he was taking. The nurse "allowed me to keep my medication at Healthcare and go there every day to take it". However, the nurse did not give him any medication to take there and then. He said that the nurse did not ask him if he was a victim of torture, or whether he wanted a GP appointment the next day, and he "did not have any GP appointments at any point during this period of detention".
52. The next day, 10 August, the Claimant said that he went to the "medication hatch" (being familiar with the process from his 2017 visit), but the medication was not there. He was not given his HIV medication until about 4 p.m. on Sunday 11 August, some 4 ½ days after he said he had taken his last dose.
53. The Defendant's records show that the consultation with the nurse took place at about 0120 on 10 August 2019, which is consistent with the Defendant's policy that it should occur within 2 hours of arrival. The belatedly disclosed screenshots contain the following in particular:

“Other current health problems: HIV positive. [details of medication] Brought in a month supply of his own medication. Declined GP. Requesting his medication to be prescribed as supervised.”

“Detainee has been questioned on history of torture: Yes

Added to R35 Assessment waiting list? not required ...

GP appointment booked? not required ...”

“11 Aug 2019 11:00 Appointments ... Rule 34 24 Hour GP Screen”.

54. The Defendant’s healthcare records also show that the Claimant had an appointment with a medical practitioner, Dr Mumtaz, at 1511 on 11 August 2019. Just after that, at about 1600, the Claimant was given his medication by a nurse.
55. Again, I find on the balance of probabilities that the records are accurate as to the details on which they contradict the Claimant’s evidence, and therefore that when he first saw the nurse, he was asked about torture and declined an assessment under the relevant rules (to which I return below), and that he declined a GP appointment on that occasion, but that he nevertheless did see the doctor on 11 August 2019.

Detention decisions

56. The Defendant’s Case Record Sheets contain logs of the interactions with the Claimant. These record that form IS91 was served at 1515 on 8 August 2019. That is the document informing each custodian that authority has been given for the person’s detention.
57. Whenever a person is detained under immigration powers, as I have said, the Defendant’s policy requires that approval must be obtained from the DGK, to whom officers in locations such as KIU refer cases.
58. A further record sheet, also dated 8 August, records Mr Lavelle stating that he is “obliged to consider detention” because the Claimant had returned in breach of a deportation order and that “a referral will also be sent to the DGK and the decision will lay with them on further detention”.
59. The next entry states that the case had been “referred to CIO Lavelle who authorised detention pending Detention Gatekeeper and CCD decision”. An email had been sent to the Detainee Escorting and Population Management Unit (“DEPMU”) to see whether the Claimant could be detained without his medication, and a reply stated that he could not. The note continues, stating that the case would be referred to DGK the next morning. That is followed by the phrase “case rejected”, meaning that the DGK had refused authority to detain in the absence of the medication.
60. According to Mr Lavelle, the Claimant was initially detained at 1610 on 8 August. The extended period in the STHF occurred because he would not give his authority for medication to be obtained from Lewisham. His consent was eventually obtained within

24 hours of initial detention but the transfer had to await the arrival of the medication, so that he finally left Dover at 2200 on 9 August 2019.

61. In a note dated 9 August, Mr Lavelle records that the medication was now being obtained from the clinic and added: “This will now enable full transfer of the detainee into more suitable detention accommodation with his medication as required by DEPMU before transfer. Proforma for DGK re-sent with additional information as required.”
62. However, Mr Lavelle was not aware of the subsequent delay in administering the medication to the Claimant and did not know the reason for it.
63. The witness statement of Emily Jarvis states that at 1724 on 9 August, she sent a message to another SEO, Ms Senvewo, which included the following:

“Detention is authorised in the short term pending asylum consideration. CC will need to explore whether this can be expedited, and subsequent removal. An ETD² will also need to be obtained. In light of the vulnerability/medical aspects of this case, the suitability of ongoing detention will need to be carefully considered and a release referral submitted to the Strategic Director should removal not be considered a realistic prospect within a reasonable timeframe. Please can you raise a review with the case progression panel for one month's time.”
64. At 1726 on 9 August 2019, Ms Senvewo communicated the DGK’s decision to “accept” the case i.e. to authorise detention, to Mr Lavelle.
65. Ms Jarvis then referred the case to a Senior Civil Servant for further authorisation. This was granted at 1935 by a Ms Fitzmaurice.
66. A 24 hour detention review also appears to have been carried out on 9 August 2019, authorising continued detention. It is signed by an EO and an authorising SEO.

Later developments

67. On 14 August 2019, the Claimant’s solicitor requested that he receive a rule 35 assessment. He was placed on a waiting list and was seen on 21 August 2019 by a medical practitioner at Harmondsworth, Dr Irfan Sayed. Dr Sayed’s report under rule 35 of the Detention Centre Rules and rule 32 of the STHFR records his concern that the Claimant may have been a victim of torture.
68. The Claimant’s solicitors also arranged for him to be interviewed by a clinical Psychologist, Dr Tim Green. Dr Green’s report dated 27 August 2019 concluded that the Claimant was suffering from PTSD and was at risk of suicide.

² Emergency travel document.

69. By a memorandum dated 29 August 2019, the Claimant was informed that in view of factors including the rule 35 report and the psychologist's report, a decision had been taken to release him from detention.
70. The Claimant was released the next day, 30 August 2019.

Issue 1: Breach of the Article 3 systems duty

71. The State has a positive duty to put in place a legislative and administrative framework to secure the health and well-being of those in detention so as to avoid harm of a kind which would engage Article 3.
72. An analogous duty under Article 2 requires health authorities to protect the lives of patients in hospitals. In *Savage v South Essex NHS Trust* [2009] 1 AC 681, the scope of the duty was described by Lord Rodger at [69]:

“In the first place, the duty to protect the lives of patients requires health authorities to ensure that the hospitals for which they are responsible employ competent staff and that they are trained to a high professional standard. In addition, the authorities must ensure that the hospitals adopt systems of work which will protect the lives of patients. Failure to perform these general obligations may result in a violation of article 2.”
73. The context in *Savage* was different, but the systems duty in relation to protecting immigration detainees from Article 3 ill treatment is of the same broad nature. Deputy Judge Saggerson in *Watling v Chief Constable of Suffolk Constabulary* [2019] EWHC 2342 (QB) described the Article 3 duty in the context of police custody, at [71]:

“This general duty requires that legislative and administrative systems are put in place which will make for effective prevention of the risk to the health and well-being of those under the control of public authorities.”
74. The claim as originally drafted alleged that there was an absence of adequate policy, rules or guidance on how detainees with HIV would be treated.
75. At the start of the litigation, the Claimant also served a request for further information under CPR Part 18, asking (among other things) whether the BHIVA guidance had been adopted by the Defendant.
76. The Defendant's Part 18 response on 8 March 2021 stated that the BHIVA guidance “is adopted by the Heathrow IRC estate (incorporating Harmondsworth when [the Claimant] resided” and that this occurred on 23 March 2019.
77. In response to that, the Claimant filed amended grounds of claim which challenged a failure to implement the adopted BHIVA guidance. That gave rise to amended grounds of defence which took issue with the Claimant's interpretation of that guidance.

78. On 17 June 2021 (six days before trial), the Defendant applied for permission to rely on a late witness statement of its Detention Safeguarding Policy Lead, Bethany Farr. That statement said (among other things):

“27. I am aware that in a response to a Part 18 request for this case dated 8 March 2021, it was stated that the BHIVA advisory document had been ‘adopted by the Heathrow IRC estate’ in response to the question ‘Please confirm: i) That the guidance has been adopted by the Defendant’. Following clarification with the Regional Operations Manager at Central and North West London NHS Foundation Trust (‘CNWL’) who are the healthcare provider at the Heathrow IRCs. I wish to clarify in this statement that although CNWL do not follow the BHIVA advisory document per se, much of the clinical content reflects existing nationally recognised clinical guidance which is considered by healthcare staff when developing appropriate local clinical procedures to support the management of those with HIV in detention.

28. To the best of my knowledge, the Home Office has not adopted or committed to adopt the BHIVA advisory document, nor has the document been implemented into policy by the Home Office.

29. As a further clarification to the above, it is noted that the response provided as to the date of adoption of the guidance was erroneously stated as 23 March 2019. The Home Office received an email from the National Aids Trust (NAT) on 22 March 2019 informing that the said guidance was being launched that day (EX BF1). It accordingly became effective from this date.”

79. By a letter dated 18 June 2021, the Claimant’s solicitors asked a number of questions about this change of position, including whether the Defendant intended to re-amend her case, and also asked whether Ms Farr (who joined the Home Office in January 2021) would be able to answer questions at the hearing about policy and practice relating to the period from 2017 to 2019.

80. Late on 21 June 2021, the Defendant applied for permission to re-amend her grounds of defence and to rely on a witness statement by Terry Gibbs, who has been a Service Delivery Manager for the IRCs at Heathrow since 2015. The signed witness statement was provided on 22 June, the day before the hearing.

81. The new statement reveals that it was Mr Gibbs whose instructions led to the Defendant’s Part 18 response. He states:

“17. The document ‘Immigration detention and HIV – Advice for healthcare and operational staff’, published by the British HIV Association (‘BHIVA’) and National AIDS Trust (‘NAT’) on 22 March 2019, is an advisory document developed by BHIVA, NAT and NHS England in collaboration with a number of contributors including CNWL NHS Foundation Trust, Home

Office representatives (including myself) and Non-Government Organisations. The Home Office representatives were involved in constructive engagement during the development of the BHIVA advisory document, but did not formally endorse or adopt the document, nor expected that this would be formally adopted in the future given that the advisory document fundamentally provides advice on the management of a healthcare issue.

18. I am aware that in a response to a Part 18 request for this case, dated 8 March 2021, it was stated that the BHIVA advisory document had been “adopted by the Heathrow IRC estate” in response to the question “Please confirm: i) That the guidance has been adopted by the Defendant”. This was based on my confirmation by email, on 27 January 2021, as provided in disclosure to the Part 18 request (EX TG1). I had provided this confirmation because it was my understanding at the time, having checked with Healthcare colleagues, that the healthcare providers at Heathrow IRCs used the principles of this advisory document as a steer for the procedures in place for managing those with HIV in detention. My confirmation was not however, intended to imply that this document has been adopted by the Home Office in Heathrow IRCs or by the Home Office for all IRCs.

19. It is now my understanding that this point has been clarified the Regional Operational Manager at CNWL NHS Foundation Trust and I wish to refine my earlier statement to clarify that although CNWL do not follow the BHIVA advisory document *per se*, much of the clinical content reflects existing nationally recognised clinical guidance which is considered by healthcare staff when developing appropriate local clinical procedures to support the management of those with HIV in detention.

20. There is no site-specific clinical protocol for HIV at Heathrow IRCs, as is proposed as best practise in the BHIVA advisory document, but within local procedures, all CNWL staff are trained universally to treat all patients as though they may have a blood borne (BB) virus and/or HIV to ensure they are cared for without discrimination. With regards to specific provision available for those with HIV in Heathrow IRCs, CNWL employ sexual health trained staff who adhere to the National Institute for Health and Care Excellence (NICE) guidelines for the ongoing treatment and management of detained individuals with HIV. The NICE guidelines publish the aims of treatment as per the below:

“Treatment aims to achieve an undetectable viral load, to preserve immune function, to reduce the mortality and morbidity associated with chronic HIV infection, and to reduce onward

transmission of HIV, whilst minimising drug toxicity. Treatment with a combination of ART aims to improve the physical and psychological well-being of infected people.”

21. It is my understanding that the approach to managing individuals in detention with HIV taken by Heathrow IRCs, noted above, was being practised by healthcare at the time the Claimant was detained at Heathrow IRC.”

82. This confusion in respect of a simple question – whether the BHIVA guidance had become part of the Defendant’s policy – is unedifying, to say the least.
83. Be that as it may, Mr Buttler QC, representing the Claimant, submits that the position now appears to be that the Defendant has not identified any guidance which is disseminated to all of her relevant staff and which tells them (1) about the need to ensure that medication is provided to detainees who are on antiretroviral medication within 24 hours and (2) how to go about this.
84. That is illustrated, Mr Buttler contends, by what happened in the present case. Whilst the DGK rightly refused to authorise detention while the Claimant was without his medication, the officials at KIU did not immediately know how to go about obtaining it. Time was wasted in making enquiries of the NHS 111 service and in a visit to a local hospital. Mr Lavelle, commenting on the abortive hospital visit, demonstrated his lack of knowledge by stating: “As far as I was aware this was not urgent.” In another answer to a Part 18 request, he clarified that he could not remember receiving any training on dealing with detainees with HIV. A lack of awareness on the part of staff at Harmondsworth could also help to explain why no medication was given to the Claimant on 10 August 2019.
85. Mr Malik QC, for the Defendant, emphasizes the unreliable nature of the Claimant’s evidence. He submits that the Claimant set out to reduce the risk of being detained by deliberately not bringing his medication with him, and has subsequently painted a deliberately bleak but misleading picture of the events which occurred when he was detained. He cautions me against finding that there was a breach of the Article 3 duties, given the difficulty of establishing the facts.
86. Mr Malik also relied on the evidence of the Defendant’s witnesses. Ms Farr told me that she received training on the needs of vulnerable detainees though not specifically in relation to HIV.
87. Although the nature of the systems duty is not in dispute, Mr Malik submitted that it was, or could be, sufficient for the Defendant to have a system in which staff could access information when they needed it, even if they did not know in advance how to deal with every medical condition with which they might be confronted. It would not be realistic, he contended, to require the Defendant to have a specific policy in relation to every medical condition.
88. Mr Malik therefore relied on the fact that the AARP generally addresses the needs of vulnerable detainees. There is also information on the Defendant’s website which warns individuals attending screening that they may be detained, and advises them to bring with them a supply of anything they might need, specifically including medication. The

standard screening questionnaire includes a question about medication, which can therefore be expected to identify needs of that kind. Detention at a STHF will not normally last more than 24 hours. At an IRC there are healthcare facilities with access to doctors and a new detainee will see a nurse within 2 hours. At the outset of detention, there is also the safeguard of the DGK, who in this case picked up the medication problem and responded to it.

89. In the present case, Mr Malik submits, the system was shown to be adequate. Although the lack of medication was a problem deliberately created by the Claimant, the Defendant's staff found out what to do, and medication was in fact obtained by the evening of 9 August 2019 although there may have been a delay in administering it.
90. I agree with Mr Buttler that these events in August 2019 demonstrate the lack of a sufficient system. The staff at KIU did not know how to obtain the necessary medication. When it was obtained, staff at KIU and/or at Harmondsworth failed to appreciate the need to administer it without delay.
91. The Defendant's other relevant policies, such as the AARP, do not contain specific guidance on how to care for detainees with HIV. I am not reassured by the evidence of Mr Gibbs which is quoted above. Healthcare staff in the present case did not apply their training, and there is no sign of any relevant training being provided to immigration officers.
92. Whilst I accept Mr Malik's argument that it would be disproportionate to require a policy to deal with every specific medical condition, the existence of the BHIVA guidance which was created specifically for immigration detention, with input from the Home Office, demonstrates the existence of a serious problem affecting a significant number of people.
93. The nature of the problem is highlighted in two letters from Dr Rosenvinge, the Claimant's treating consultant. The first, dated 23 March 2018, says:

“[the Claimant] requires antiretrovirals lifelong. He has to take the medication at exactly the same time every day. If he has any interruption to his treatment his immune system may become severely depressed and it would place him at risk of severe opportunistic infections and death.”
94. The second letter, dated 20 August 2019, says:

“I am really quite concerned that when he was detained a week ago, he went without his HIV medications for four days. This is very serious indeed. This could easily mean that his HIV virus rebounds and that he may develop further resistance to his medication which makes it more difficult to manage in the future.”
95. Those views reflect the BHIVA guidance.
96. A letter dated 25 November 2019 and signed by the Director of Policy and Communications at NAT, the Head of Policy and Public Affairs of the Terrence

Higgins Trust and Dr Laura Waters, the Chair of BHIVA, states that a gap in treatment provision would be particularly serious for a patient who, like the Claimant, had a history of advanced HIV infection with low CD4 count which put him at an increased risk of opportunistic infections, and who had multi-drug resistant HIV which limited his treatment options.

97. The problem is serious because of the nature of ART treatment and the dangers of interrupting it, even for a short time. The possible consequences of an interruption are sufficiently serious to engage Article 3. The provision of training and information to all relevant staff to ensure that such an interruption is avoided (whether by provision of medication or by release) would not be disproportionate, in my judgment. Staff simply need to know (1) that the medication must not be missed and (2) how to obtain it.
98. It is for the Defendant to consider what policy or guidance to adopt, and then to adopt and disseminate it properly. It is not for the Court to dictate that this should be the BHIVA guidance. However, if the Defendant were to form the view that the BHIVA guidance is suitable, then there appears to be no obstacle to its adoption.
99. I conclude that there has been a breach of the systems duty under Article 3.
100. It is agreed that, in order to show a material breach of that duty, the Claimant does not have to show that he actually suffered serious harm as a result of the breach, though a lack of harm may mean that there is no right to damages. The Court of Appeal ruled that this is the correct approach to a breach of the Article 2 operational duty in *Sarjantson v Chief Constable of Humberside Police* [2014] QB 411, per Lord Dyson MR at [27-29]. I see no reason why a more stringent test should be applied to the systems duty and, as I have said, the relevant duties under Articles 2 and 3 are essentially the same.
101. The Claimant is therefore entitled to declaratory relief but not, in the absence of evidence of harm, to compensatory damages.
102. Having found a breach of the Article 3 systems duty, I do not need to rule on Mr Buttler's alternative submission that a similar duty arose, and was infringed, under domestic law. The parties agreed that there was no material difference between the scope of the Article 3 duty and any correlative domestic duty.

Issue 2: Breach of the Article 3 operational duty by failing to provide medication until the afternoon of 11 August 2019

103. In certain circumstances the State owes a positive protection or "operational" duty under ECHR Article 2 (which protects the right to life) or under Article 3, to take measures to protect individuals who are at risk of death or of harm which is sufficiently serious to engage Article 3.
104. In *Rabone v Pennine Care NHS Trust* [2012] UKSC, [2012] 2 AC at [22], Lord Dyson said:

“... the operational duty will be held to exist where there has been an assumption of responsibility by the state for the individual’s welfare and safety (including by the exercise of control). The paradigm example of assumption of responsibility is where the state has detained an individual, whether in prison, in a psychiatric hospital, in an immigration detention centre or otherwise. The operational obligations apply to all detainees, but are particularly stringent in relation to those who are especially vulnerable by reason of their physical or mental condition: see, for example, *Keenan v United Kingdom* 33 EHRR 913 (prisoner suffering from a mental disorder) and *Tarariyeva v Russia* (2006) 48 EHRR 609 (person detained in a prison hospital suffering from a serious physical illness).”

105. That duty will arise where there is a real (not fanciful) and immediate (present and continuing) risk of the relevant harm: *ibid* at [38-39].
106. Those conditions are satisfied in the present case, so that an operational duty arose. At all times the Defendant, by her officials, knew or should have known that the Claimant required his HIV medication and that an interruption of it could be particularly dangerous for him.
107. The nature of the operational duties under Articles 2 and 3 is the same: *Rabone* at [104] per Lady Hale. The obligation is to take all reasonable steps to avoid a real and immediate risk of the relevant harm. In an Article 3 case, that means substantial and significant harm.
108. As I said in the context of the systems duty above, a Claimant need not show that a breach of the duty resulted in actual harm.
109. However, it is necessary to show a material breach of the operational duty. The “all reasonable steps” test does not mean that any shortcoming will be sufficiently serious to infringe Article 3.
110. On that issue, it seems to me that this is a borderline case. I have found that the Claimant had taken his medication on the morning of 8 August 2019 and that he told the Defendant’s staff this. The steps taken to obtain medication for him were by no means perfect. As I have said, it is regrettable that officials on 8 August 2019 did not know how to go about this. Nevertheless, the medication was obtained in the course of 9 August 2019, that being the next day on which it would be needed. Progress on that day was delayed by the Claimant’s unwillingness to consent, and this should not be laid at the Defendant’s door.
111. The problem was that although the medication was obtained by the evening of 9 August, it was not administered until the afternoon of 11 August.
112. If the only failure were a failure to administer a dose on the evening of 9 August, it would be difficult to conclude that the Defendant was in breach of the duty, in particular because there is no evidence on whether it is appropriate to give a dose in the evening if it is usually taken, and was missed, in the morning.

113. However, there was an entire and unexplained failure to make the medication available on 10 August 2011. Mr Malik suggests that it may in fact have been administered but if it had, then it seems to me that this would be seen in the records, so I am satisfied that it was not.
114. Moreover, the dose on 11 August was due in the morning but was delayed until the afternoon. Again, no explanation is given.
115. This overall delay of at least 1½ days was made more serious by the fact that the Claimant had also not taken the medication on 9 August, even if that day is not added to the period of delay which is said to amount to a breach of duty.
116. I bear in mind the BHIVA guidance that the occasional missed dose, though strongly contra-indicated, may be tolerated. But as I have said, the question is not whether harm was caused, but whether there was a failure to take reasonable steps to avoid a risk of harm.
117. In view of the medical evidence to which I have referred, it seems to me that the failure was material. Therefore there was a breach of the operational duty.
118. However, there is again no evidence that the breach caused any harm. It satisfies a test of materiality by a narrow margin, given the short period of time which was involved. I do not consider that any damages of a compensatory nature should be awarded for that breach of duty, or indeed for the breach of the systems duty considered above.

Issue 3: false imprisonment

119. As Mr Buttler submitted, it is for the Defendant to prove that detention was lawful, and not for the Claimant to prove that it was not.
120. Mr Buttler further submits that in this case, there were a series of public law errors which were relevant to the decision to detain and that, applying *Lumba*, the Claimant's detention was therefore unlawful. The alleged errors are:
 - i) When the Claimant was first detained at 1511 on 8 August 2019, Mr Lavelle did not have regard to the IOI and its effect on the possibility of and timescale for removing the Claimant from the UK.
 - ii) The DGK refused authority for continued detention at 1754 on 8 August 2019 but the Claimant was not released.
 - iii) At 1515 on 9 August 2019, the Claimant had been detained in the STHF for 24 hours. Contrary to the STHFR, further detention was not properly authorised by being subjected to a test of exceptional circumstances.
 - iv) By the end of 10 August 2019 (or at about 0045), no or no proper rule 34 examination had taken place within 24 hours of the Claimant's arrival at Harmondsworth.
 - v) At about 1700 on 23 August 2019, the rule 35 report had not been considered within 2 working days of receipt.

121. It is common ground that causation – i.e. whether detention would have occurred in the absence of any relevant errors – is a separate question, upon which turns the availability of any compensatory damages.
122. It is therefore necessary to consider each phase of detention and the legal effect of each of the matters of which the Claimant complains.
 - (i) *the IOI and the initial decision to detain*
123. As I have said, the IOI of June 2019 stated in particular: “With immediate effect and until further notice, staff should refrain from pursuing the detention and enforced return of DRC nationals.”
124. Mr Buttler does not contend that any detention of a DRC national at this time would necessarily have been unlawful, accepting instead that policy statements can be departed from if there is good reason to do so. However, he submits that the existence of the IOI was plainly a relevant factor in any decision to detain a DRC national at this time. In the Claimant’s case that was all the more evident because his case was one of those referred to in the report which had given rise to the IOI (see paragraph 21 above).
125. Mr Malik invited me to construe the IOI as applying only to the exercise of the power to detain and remove at the same time. In other words, the real restraint was on removing individuals to the DRC, which was why it would also apply to the act of detaining a person in order to effect such removal. However, Mr Malik argued, it would not apply to a case such as this, where the pending asylum claim meant that removal was still some way off, and the correct approach would be to apply the *Hardial Singh* principles.
126. In my judgment, it is necessary to have regard to the IOI and *Hardial Singh* together. The immediate practical effect of the IOI was to prevent removals to the DRC until further notice. A decision maker, applying the third *Hardial Singh* principle (see paragraph 14 above), would need to have regard to the IOI when deciding whether removal could be effected within a reasonable period. It is true that, as Mr Malik said, the IOI applies to “detention and enforced removal” (emphasis added), but that is because any detention would be for the purpose of the removal. It therefore seems to me that the IOI placed at least an inhibition on any decision to detain a person with a view to removal.
127. In evidence, Mr Lavelle admitted that he had not been aware of the IOI when initially detaining the Claimant and that its existence was relevant information. He said that if he had known about it, he would have referred the decision to a more senior officer to decide whether detention was appropriate notwithstanding the IOI.
128. That being so, it is clear that the overlooking of the IOI was a public law error, meaning that the initial decision to detain was made without regard to a relevant factor. Applying *Lumba*, detention therefore amounted to false imprisonment with effect from 8 August 2019, and the Claimant is entitled to a declaration to that effect.
129. However, both parties are content for me to decide on the evidence before me whether detention would have occurred even if that public law error had not been committed. If

so, the Claimant is entitled only to nominal damages for that breach of his rights. The burden of proof is on the Defendant.

130. In my judgment, it is probable that the Claimant would still have been detained if Mr Lavelle had referred the case to a senior officer in light of the IOI. That is because of the factors to which Mr Malik referred. This was always a case where, because of the pending asylum claim, removal was not imminent. Detention in those circumstances would be subject to regular and careful reviews, applying the *Hardial Singh* principles. But this Claimant had been deported and had returned to the UK illegally. Whilst he had on this occasion made himself known to the authorities, and his asylum claim now created a disincentive for him to abscond, nevertheless he had evaded the authorities for some time since returning to the UK. In view of his immigration history (and having regard to the decisions which were made, notwithstanding that the Claimant was a person at risk), I consider it very likely that the Defendant would have judged detention to be appropriate, although the continuing effect of the IOI would have been kept in mind, and such detention would no doubt have ended if and when returns to the DRC were judged to be impracticable on a long-term basis.
131. It then remains to decide whether subsequent events should have led to the Claimant's release at any point, so that he is entitled to compensatory damages for any continuation of his false imprisonment.

(ii) refusal of authority by the DGK
132. As I have said, the DGK refused authority for continued detention at 1754 on 8 August 2019. Mr Buttler submits that the Defendant thereupon had no lawful option but to release the Claimant, so that a new phase of false imprisonment started at that point.
133. Ms Jarvis in her statement explains that authority was refused because of the lack of HIV medication. At that time DEPMU had advised that it would not be possible to obtain medication for 3-4 weeks.
134. The case was re-referred to the DGK around 24 hours later. The CID notes record that at 1721 the DGK was told that he had now given consent for his medication to be obtained that day. Approval for detention was granted.
135. The question is what was the legal position in between those two events.
136. The facts of this case demonstrate that front-line staff needed some power to make short-term detention decisions, pending DGK decisions. That happened, for example, when Mr Lavelle made the initial detention decision in the present case, and it is not suggested that he lacked that power.
137. Mr Malik first made the point that the statutory authority to detain arises from the issue of a form IS91, not from a decision by the DGK (though that point is weakened by the fact that the forms in the present case as completed by Mr Lavelle refer to initial detention, with any further detention to be authorised by the DGK). He then submitted that, consistently with an orthodox public law approach to policy, a case owner must follow the DGK's recommendation to release unless there is good reason to depart from it. Continued detention under the statutory authority and re-referral to the DGK where

a case owner is satisfied that missing medication could be obtained quickly is consistent with the DGK scheme.

138. Mr Buttler accepts in principle that the Defendant could lawfully promulgate a policy permitting continued detention if a problem identified by the DGK can be solved quickly, but makes the objection that there is no such policy.
139. The problem of the lack of any written policy on this subject was compounded by a lack of clear and consistent oral evidence. Bethany Farr, the Defendant's Detention Safeguarding Policy Lead, was asked whether a refusal of authorisation by the DGK meant that an individual must be released, and replied that she did not know. Ms Jarvis was slightly more helpful. In re-examination she was asked whether, after a refusal, an officer could continue detention in light of a change of circumstances. She said that if the DGK had refused authority, a front-line officer could detain the individual under the authority of the existing form IS91 and then re-refer the case. However, she was not referred to any documentary or other evidence to confirm this approach.
140. In my judgment, there is only a limited difference between the situation where the DGK refuses authority to detain but a front-line officer has good reason to believe that the obstacle to detention can be quickly removed, and the situation where a front-line officer initially detains an individual pending a DGK decision. It could be argued that the officer in the former situation should formally release the detainee and then immediately re-detain them, but that would introduce an unnecessary level of formality or complexity.
141. It seems to me that a common-sense interpretation of the unwritten DGK policy can accommodate a rapid re-referral to the DGK, without release, in this type of situation i.e. where the facts justify it. That interpretation does not bypass the independent safeguard of the DGK as Mr Buttler suggested. It is inherent in the operation of the DGK system, in a case where a problem identified by the DGK can be addressed quickly.
142. I therefore reject the alternative construction, that a person in the Claimant's position must be released, even if the problem identified by DGK could be quickly resolved and even if factors in favour of detention (e.g. a risk to the public) are overwhelming.

(iii) Detention in the STHF beyond 24 hours

143. At 1515 on 9 August 2019, the Claimant had been detained in the STHF for 24 hours. I have already referred to rule 6 of the STHFR, which stated that continued detention in the STHF could be authorised "if the Secretary of State determines that exceptional circumstances require it". I have also referred to the Defendant's policy which required such a decision to be taken in advance, by a senior officer, in person if possible, and recorded in detail.
144. Mr Buttler submits that no such authority was granted and therefore detention became unlawful at that point. Mr Lavelle's witness statement, he says, is not sufficient to show that proper authority was granted, in particular because there is no evidence of a test of exceptional circumstances being applied. Mr Lavelle simply states:

“A further call was made on 9 August 2019 with HMI Ikhson HUSSAIN prior to the 24hrs being reached to inform him of the situation and reason why the Claimant was being kept in the STHF for more than 24 hours.”

145. Mr Malik accepts that the evidence is not very clear, but points to the heading preceding that paragraph in the statement which states that “authorisation was obtained”. Authorisation can be, and was, obtained by telephone. HMI Hussain’s consideration of the case was recorded in a handwritten note on the record of the 24 hour detention review.
146. In the alternative Mr Malik submits that any breach of rule 6 was not material.
147. The latter point is the better one. The evidence does not show that a test of “exceptional circumstances” was applied and there was no proper record of a reason for authorising continued detention in the STHF. I therefore consider that a public law error (or errors) vitiated the authority to detain for a few hours until the Claimant left for Harmondsworth. However, it is more than probable that a proper application of the STHFR would have resulted in a decision that the delay caused by obtaining medication was an exceptional circumstance which justified the 24 hour limit being exceeded for a short time.
- (iv) Breach of rule 34 of Detention Centre Rules 2001*
148. Rule 34 is quoted at paragraph 26 above.
149. In *R (EO & Ors) v Secretary of State for the Home Department* [2013] EWHC 1236 (Admin), the Defendant conceded that a failure to conduct a rule 34 assessment within 24 hours of admission to a detention centre is a material public law error which vitiates the Secretary of State’s authority to detain (see [51] per Burnett J, as he then was).
150. The Claimant’s case on this issue has undergone some evolution. Ground 2 of the claim was pleaded only as an omission to ask the Claimant, during his initial rule 34 examination, whether he claimed to be a victim of torture.
151. As to that allegation, I have already referred to the screenshots containing the record of the rule 34 examination. These were disclosed extraordinarily late, the day before the hearing, an omission for which there is no good excuse. Nevertheless, they provide what is, on the face of it, credible evidence that the question about torture was asked. The usual approach in judicial review is to resolve factual disputes in favour of the Defendant, but that gives way in a case such as this where cross-examination of witnesses has been permitted. Nevertheless, where there is an unresolved conflict between the Claimant’s recollection and a documentary record, I prefer the latter, and I am not persuaded that there was a breach of rule 34 as alleged.
152. In Mr Buttler’s skeleton argument, however, he advances two different points. First, that the Claimant was not seen by the GP until 39 hours (rather than 24 hours) after his arrival at Harmondsworth. That, it is agreed, would sound only in nominal damages. Second, that the GP appointment was concerned only with his ART medication and did not include a mental examination. Had a mental examination taken place on 10 or 11

August, Mr Buttler submits, it would have led to the conclusion reached by Dr Sayed on 21 August, namely that detention would damage the Claimant's mental health.

153. As to the first of those points, Mr Malik submits that the delay in the examination occurred because the Claimant initially declined the offer to see the doctor, as is recorded by the screenshot referred to at paragraph 53 above, and is therefore excused by rule 34(2). Although the Claimant when cross-examined said that he did not decline an appointment, he also said that there was no need for him to see a GP.
154. As to the second point, Mr Malik refers to the screenshot which, against 11 August 2019, states "Rule 34 24 hour GP Screen". That being so, he invites me to find on the balance of probabilities that the GP knew that he was conducting a rule 34 examination and would have covered the necessary ground including mental health as a matter of course.
155. The medical notes are brief and monosyllabic. They do not mention any medical condition other than HIV and contain detailed reference only to the ART medication.
156. Although the evidence is exiguous and the burden of proof is on the Defendant, I am persuaded by the documentary records that there was no breach of rule 34. After an initial refusal by the Claimant, a rule 34 examination was conducted. I bear in mind that the specific allegation of a failure to conduct a mental examination was not the allegation originally pleaded, and it might have been further investigated if raised earlier. In the absence of further investigation, I consider it probable that the rule 34 examination covered the necessary ground although the documentary record is less than satisfactory.
157. If I am wrong about that conclusion, I consider that any breach of rule 34 would have given rise only to nominal damages. The evidence suggests limited willingness by the Claimant to engage with medical examination at that point and a perception that it was not necessary. In those circumstances I cannot conclude that a mental examination would have led to an earlier release.

(v) Failure to consider the rule 35 report within 2 working days

158. The Defendant's officials received Dr Sayed's rule 35 report on Wednesday 21 August 2019.
159. Rule 35(4), quoted at paragraph 26 above, requires a manager to send a rule 35 report to the Defendant without delay. The Defendant's Detention Services Order 09/216 provides:

"A rule 35 report must be considered and be responded to by the responsible officer in line with the guidance in chapter 55b – Adults at risk in immigration detention. These actions must be carried out as soon as possible but no later than the end of the second working day after the day of receipt. The responsible officer must copy the response to the detainee's legal representative (if one is recorded on file) at the point of response.

Responsible officers have two working days after accepting receipt to provide a response to the rule 35 report. The response must:

- engage with the concerns raised by the doctor in accordance with the guidance in chapter 55b – Adults at risk in immigration detention
- where detention is being maintained, set out clearly the reasons why
- where detention is not being maintained, set out clearly the reasons why
- clearly identify the responsible officer’s name and team”.

160. The Secretary of State has accepted that a failure to respond within two working days, in accordance with this policy, renders her liable for false imprisonment (the case of *EO & Ors*, cited above, at [93]).

161. In this case there was no response to the rule 35 report until 29 August 2019, when it was announced that detention would not be maintained. Mr Buttler contends that compliance with the policy on 23 August, rather than 29 August, would have accelerated the Claimant’s release by 6 days and therefore that the Claimant was falsely imprisoned for that period.

162. Mr Malik submits that if there was a failure to comply with the rule 35 policy, this was a public law error only if it was without good reason, and in any event that the Defendant has a “grace period” within which to make any necessary arrangements once it becomes apparent that an individual must be released and before continued detention amounts to false imprisonment.

163. As to good reason, Mr Malik relies on the statement of Ms Farr, who said:

“The reason for this extended period to the response was due to delays in obtaining the required information on risk-assessment and accommodation suitability from the probation service which are required as part of the submission for release authorisation.”

164. Ms Farr in cross-examination said that this information came from colleagues including a Mr Crook, who was the head of the rule 35 team, and that she herself could not assess its accuracy.

165. There is no other evidence to corroborate what is said about contact with the probation service. If there are any relevant documents, the Defendant should have disclosed them.

166. I also note that nothing is said about any delay caused by discussions with the probation service in the ensuing report of 29 August 2019. Also, whilst matters of that kind might have delayed final release (a fact which should be provable by specific evidence), they would not necessarily have justified a delay in deciding whether or not detention was to be maintained.

167. In my judgment, the Defendant has not discharged the burden of proving that there was a good reason for exceeding the policy requirement of two working days for the response. A non-specific and second-hand reference contained in one sentence of a witness statement is not sufficient.
168. I conclude that the Claimant was falsely imprisoned for a short period as a result, and the factors in his immigration and personal history which initially justified detention do not persuade me otherwise.
169. The report provided on Thursday 29 August led to release on Friday 30 August. Bearing in mind that the policy refers to working days, I cannot assume that a report on Friday 23 August 2019 would have led to release on the Saturday rather than on Monday 26 August. On the balance of probabilities, I conclude that a delay of 4 working days caused 4 days' false imprisonment, for which the Claimant is entitled to be compensated.

Conclusion

170. The breaches of Article 3 duties identified at paragraphs 99 and 117 above and the public law errors identified at paragraphs 128 (in relation to the IOI) and 147 (in relation to the STHFR) entitle the Claimant only to declaratory relief. Following circulation of this judgment in draft and an exchange of draft orders, I have decided the terms of the appropriate declaration.
171. The Claimant is entitled to compensatory damages for the period of false imprisonment identified at paragraphs 168-169 above. Following circulation of this judgment in draft, the parties have agreed that the damages claim will be stayed for 12 weeks for negotiations and thereafter will be transferred to the Central London County Court if agreement has not been reached.

Costs

172. Following circulation of this judgment in draft and an exchange of written submissions, I will order the Defendant to pay the Claimant's costs, to be assessed on the standard basis up to 7 March 2021 and on the indemnity basis from 8 March 2021.
173. In this judicial review application the Claimant is plainly the successful party and is entitled to costs. The ongoing dispute about quantum of damages, and any offers which have been made in relation to that dispute, will not disturb that conclusion. The costs of that continuing dispute will be for determination later if they are not agreed.
174. In my view it is appropriate to order indemnity costs for the phase of the judicial review which began with the Defendant's Part 18 reply referred to at paragraph 76 above. The provision of incorrect information in that reply, and the ensuing u-turn which was followed by exploratory oral evidence, unnecessarily made this litigation more complex and more expensive. I am satisfied that this was a substantial development which took the conduct of the litigation outside the norm so as to justify indemnity costs, applying the principles discussed in *Excelsior Commercial and Industrial Holdings Ltd v Salisbury Ham Johnson* [2002] EWCA Civ 879 and elsewhere.

175. As Mr Malik submitted, the unreliable nature of the Claimant's evidence on a number of points weakened his position on costs generally. However, in my view that point was outweighed by the impact of the Defendant's misleading information on the major issues in the case, and by the fact that documents countering the Claimant's case on issues of fact, discussed above, which could have been located and disclosed much earlier, were not disclosed until the last possible moment. It remains just and proportionate for the costs of the final phase to be assessed on the indemnity basis.