



Neutral Citation Number: [2021] EWHC 3165 (Admin)

Case No: CO/972/2020

IN THE HIGH COURT OF JUSTICE
IN THE ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26.11.21

Before :

MR JUSTICE RITCHIE

Between :

THE QUEEN (ON THE APPLICATION OF OK)

Claimant

- and -

THE ROYAL FREE LONDON NHS FOUNDATION TRUST

Defendant

- and -

DOCTORS OF THE WORLD (1)
THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE (2)

Interveners

(Simon Cox instructed by Deighton Pierce Glynn) for the Claimant
(David Lawson instructed by Bevan Brittan) for the Defendant
(Jamie Burton QC and Admas Habteslasie instructed by Bhatt Murphy) for the 1st Intervener
(Joseph Barrett instructed by the Government Legal Department) for the 2nd Intervener

Hearing dates: 16 November 2020

Approved Judgment

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The parties

- [1] The Claimant is an individual who was living in England at the relevant time.
- [2] The Defendant is an NHS hospital foundation trust.
- [3] The first intervener, Doctors of the World (DoW) is a charitable organisation interested in the provision of medical healthcare to disadvantaged individuals.
- [4] The second intervener is the Secretary of State for the department which funds the Defendant.

The issues

- [5] This judicial review claim relates to the decisions made relating to the provision or non provision of urgent services to an Overseas Visitor with kidney damage living in England.
- [6] The 1st issue is, if the Claimant needed “urgent services” on the 11th of December 2019, whether the Defendant’s decision to change from providing scheduled dialysis to ad hoc attendance at A & E for clinical assessment of his needs and if necessary dialysis (without prior payment), involved a misdirection of law, the taking into account of a factor which should not have been considered (immigration status), and/or was made without taking into account a factor which was required by law to be taken into account (the relevant timescale) or was perverse.
- [7] The 2nd issue is, if the Claimant needed “urgent services” on the 31st January 2020, whether the Defendant’s decision to advise him to attend in future every week on Wednesdays (or more frequently) at A & E for assessment and if necessary dialysis (without prior payment), involved a misdirection of law and/or the taking into account of a factor which should not have been considered (immigration status) and/or was made without taking into account a factor which was required by law to be taken into account (the relevant timescale) or was perverse.
- [8] The 3rd issue is whether, if the Claimant did need “urgent services”, the decisions made on the 11th of December 2019 and 31st January 2020 as to (a) the treatment plans, (b) the location of treatment, (c) the frequency of treatment and (d) the standard of care proposed, are administrative decisions which are susceptible to judicial review on the evidence.
- [9] The 4th issue is whether the judicial review claim is now academic and has been for a long time in the light of: (1) the provision, starting on the 27th of March 2020, of scheduled, twice weekly dialysis at the Mary Rankin Centre; and (2) the provision in October 2021 of the grant of leave to stay in England for 30 months to the Claimant by the Home Office.

Evidence and bundles

- [10] For the hearing I had before me 6 bundles, bundle one was a core bundle containing the court documents and a witness statement from the Claimant and a witness

statement from Dr. Goodlad. The second bundle contained correspondence and medical notes. The third bundle was provided by DoW. There was a fourth bundle provided by the Secretary of State. The 5th bundle contained the authorities. The 6th bundle was provided by the Claimant late in the day and contained more correspondence and the Claimant's medical records. I also had an additional witness statement from Dr. Cross which Mr. justice Murray did not have.

- [11] I was also provided with written skeleton arguments by both the parties and both interveners.

The summary of statement of grounds and response

- [12] On the 5th of February 2020 the Claimant instructed solicitors and sought legal aid to bring judicial review proceedings of the decisions relating to the care he had received and was receiving from the Defendant. It was withdrawn on 4 June 2020. At some later stage the funding was on a conditional fee agreement. The Defendant complains that it was not told that had occurred until this hearing.

- [13] The Defendant disclosed to the Claimant his medical records on the 2nd of March 2020.

- [14] On the 10th of March 2020 the Claimant issued a claim form under CPR part 8 for judicial review of and the quashing of two decisions made by the Defendant, the first on the 11th of December 2019 and the second on the 31st of January 2020.

- [15] In para 7 of the Claimant's Grounds and Remedies it was claimed:

“By this claim, C contends that D misdirected itself in law and/or acted perversely in determining that, in C's case, chronic scheduled dialysis is not an “urgent service” under reg 3(1A) as interpreted in light of D's duty under s 6 of the Human Rights Act 1998 (“HRA 1998”) not to subject C to inhuman or degrading treatment contrary to art 3 of the European Convention on Human Rights (“ECHR”) or to subject him to a disproportionate interference with his right to respect for private life contrary to art 8 ECHR.”

- [16] The reasons given were that the Defendant had provided the Claimant with regular scheduled dialysis three times a week between August 2019 and the 10th of December 2019 but with drew it on the 11th of December 2019. The Claimant asserted physical and mental suffering verging on a breach of Article 3 of the European Convention on Human Rights, through inhuman or degrading treatment.

- [17] In the Claimant's Grounds and Remedies, dated the 9th of March 2020, the Claimant referred to the correspondence between the parties. Firstly a letter before action dated 7th of February 2020 requesting a restart of routine scheduled dialysis three times a week and asserting that it was either immediately necessary or an urgent service. The Claimant referred to the Defendant's pre-action protocol response letter dated 21st of February 2020 in which the Defendant admitted that it withdrew routine scheduled treatment on the 11th of December 2019 but instead offered and provided urgent treatment on an ad hoc basis until the 31st of January 2020 when the Claimant's treatment plan was changed to weekly dialysis on Wednesdays, if blood tests and examinations at A & E mandated it under the urgent service gateway in the relevant

legislation. The Defendant denied that it had refused treatment, unfettered by up front payment, and asserted they were giving urgent services treatment under a plan.

[18] Grounds asserted:

“Ground 1

The Defendant misdirected itself in law as to the meaning of “urgent service” in regulation 3(1A) of the NHS Overseas Visitors Regs 2015

54. C submits that “urgent service” means a service which is clinically indicated as appropriate before the patient is expected to leave the UK. In the absence of a clinical decision that C does not require chronic scheduled dialysis, it remains an “urgent service” and D is required to provide it in advance of payment.”

“Ground 2

Alternatively to Ground 1, the Defendant’s self-direction in law as to the meaning of “urgent service” in regulation 3(1A) of the NHS Overseas Visitors Regs 2015 violates sections 3 and 6 of HRA 1998, in that it gives rise to conditions which verge on inhuman and degrading treatment within the meaning of art 3 ECHR.”

[19] The remedies sought were: quashing of the two clinical decisions; a declaration as to the true interpretation of Regulation 3(1A) of the *NHS (Charges to Overseas Visitors) Regulations 2015*; a declaration that the Defendant had withheld dialysis from the Claimant in breach of S.s 3 and 6 of the *Human Rights Act 1998* and Art 3 of the ECHR; anonymity and interim relief.

[20] By an order dated the 10th of March 2020 Mr justice Garnham granted the anonymity order sought until disposal of the claim, adjourned the application for interim relief pending service on the Respondent and gave directions.

[21] On the 24th of March 2020, in the Grounds of Resistance, the Defendant asserted that permission for judicial review should be refused and that no interim relief should be granted because the Defendant was providing dialysis to the Claimant weekly and because the clinical decisions made by the Defendant’s clinicians about urgent treatment were ones which provided no scope for judicial review. In addition the Defendant responded that the asserted breach of Art 3 of the ECHR was unarguable because dialysis was being provided. The Defendant pointed out that the Claimant did not base the judicial review on any immediate necessity grounds but only on the urgent service grounds. The Defendant admitted that the Claimant was likely to come to harm with no treatment. The Defendant relied on the clinical plan made by a consultant, Dr. Goodlad, in late January 2020 setting out that the Claimant had recovered a little kidney function and required at least weekly dialysis to avoid significant harm and potential loss of life in the medium term and that the Claimant had been invited to attend hospital on Wednesdays to obtain that dialysis. The Defendant admitted that the Claimant’s need for dialysis was urgent in that it could not wait until the Claimant left the UK. As to the frequency, the Defendant asserted that there was no medical evidence to support the assertion that the Claimant needed dialysis three times a week. The Defendant referred to the Claimant’s blood tests which were within the appropriate range between December 2019 and the end of February 2020. The Defendant also asserted that the Claimant’s suffering alleged after the December decision was very similar to the suffering he reported before the Defendant’s decisions, when he was having dialysis three times a week.

- [22] In the Reply dated 25th March 2020 the Claimant accepted that there was no disagreement on the Defendant's exercise of clinical judgment (para 6). The Claimant noted that it was common ground that the Claimant needed dialysis "at least weekly". In ground one the Claimant relied on a new assertion arising from the Defendant's served witness statement from Dr. Goodlad, which contained the admission that the "normal" clinical treatment for a person ordinarily resident in England would be two dialyses per week. The Claimant asserted that he was receiving "inferior treatment" because he was an overseas visitor. The Claimant also asserted that no financial evidence had been provided by the Defendant to show that providing dialysis through A&E was cheaper than providing it from the Mary Rankin Centre. The Defendant should, on the Claimant's case, have provided the normal service that any other Ordinarily Resident person in England would have received, namely dialysis twice a week at the Mary Rankin Centre.
- [23] On the 27th of March 2020 Mr justice Fordham considered the application for interim relief on paper and refused it. He continued the anonymity order. He refused permission for the judicial review on both grounds. He considered that there was no arguable claim.
- [24] On the 30th of March 2020 the Claimant renewed the application for permission.
- [25] On the 6th of May 2020 Mr justice Murray noted that the Claimant was receiving dialysis twice a week at the Mary Rankin Centre. He granted permission for judicial review on ground one but refused permission on ground two. He made directions for the further conduct of the claim. His reasons were:

"Reasons:

19 This claim turns on the proper interpretation of Regulation 3 of the 2015 Regulations, and specifically the meaning of the term "urgent service" in Regulation 3(7). The applicant says that Ground 1 is properly arguable for the following reasons:

- i) It is common ground that regular twice or thrice weekly dialysis sessions are not "an immediately necessary service" for the purposes of Regulation 3(1A) and that the treatment of the applicant's symptoms of kidney failure cannot wait until he leaves the UK (if he does).
- ii) The only clinical decision to be made under the definition of "urgent service" is whether the relevant service, in this case regular dialysis, "should not wait until the recipient can reasonably be expected to leave the [UK]".
- iii) In her witness statement at paras 24 to 25 Dr. Goodlad does not state that the treatment that, in her clinical judgment, would normally be provided should wait until a return to Nigeria. She merely states that it is not urgent in a passage explaining why it is not necessary.
- iv) In para 25 of her witness statement Dr. Goodlad does not give a clinical judgment that the scheduled dialysis she considered would normally be provided is not "urgent". Instead, she gives a clinical judgment that an inferior treatment of *ad hoc* dialysis via the A & E is "urgent".
- v) A decision to provide an inferior service to that which is clinically indicated solely on the grounds that the person is not entitled to free NHS treatment is not a clinical judgment, but a policy one.
- vi) In taking that decision, the respondent stepped beyond its role under the 2015 Regulations.

20 In the acknowledgement of service and in the respondent's skeleton argument, the respondent says:

- i) The applicant is being provided with appropriate treatment based on clinical judgment.
- ii) The care taken in this treatment can be seen and the steps taken to support him during this current public health crisis.
- iii) The applicant's division of possible treatment approaches into “chronic scheduled dialysis” and “emergency dialysis” is misconceived and unevicenced. In relation to services that "should not wait", there is no duty to provide them in a particular way or in a particular place.
- iv) Fordham J was right to refuse permission for the reasons he gave.

21 In my view, with the benefit of the additional written and oral submissions that I have had for this hearing, and which Fordham J did not have the full benefit of, I conclude that it is arguable that the applicant's interpretation of Regulation 3 of the 2015 Regulations is correct, and it is arguable that the respondent took into account an relevant factor, namely the fact that the applicant was an overseas visitor for purpose of the 2015 Regulations in deciding that *ad hoc* assessment and treatment via the A & E was the proper treatment approach, bearing in mind his inability to pay the charges otherwise required under Regulation 3(1A).”

I think there is a typo in para 21 of these reasons. I think “an irrelevant factor” is what Mr. justice Murray meant in line 5 not “an relevant factor”.

- [26] There was then a gap of a year when a number of stays were granted by the court.
- [27] On the 2nd of June 2021 the Defendant applied to put in more evidence, namely the witness statement of Dr. Cross dated the 6th of May 2021 to update the treatment being given to the Claimant and to explain her earlier decision. By that time the Claimant’s kidney function had declined and so the twice weekly dialysis which he was being provided routinely as an urgent service, was mandated on medical grounds.
- [28] On the 11th of October 2021 DoW applied to intervene by written and oral submissions and the provision of further evidence. They sought to do so on a cost neutral basis.
- [29] On the 9th of November 2021 the Secretary of State applied to intervene on the basis of written and oral submissions.
- [30] I granted both prospective interveners permission to intervene.

The facts

- [31] The Claimant, who was born on the 23rd of August 1965, is now aged 56. He is Nigerian and he came to England in 1990. He married a British Citizen in 1993. He divorced at a time unknown to me. He has three children, X aged approximately 24, Y aged approximately 23 and Z aged approximately 21. They live in England.
- [32] In 1996 he was granted indefinite leave to remain in England due to his marriage. He remained lawfully in England until 2014.
- [33] In 2012 he was convicted of importation of cannabis and possession of false documents and imprisoned for a term of 38 months. Thereafter he was detained under immigration powers and was released in June 2016. In the mean time a deportation

order was made in 2014 and he appealed against it. The criminal convictions were the reason for the order. The appeal was dismissed.

- [34] On his release from prison in 2016 the Claimant applied for leave to stay on human rights or compassionate grounds including the presence of his children/family in the country. When the decisions which are the subject of the claim were made and when the claim form in the judicial review was issued that application had not yet been decided.
- [35] So as at the date of the relevant events in 2019 and 2020 it is agreed that the Claimant's immigration status was as an "Overseas Visitor" (OV). I understand that the effect of that status is that he did not have permission to work in England and he did not have the right to receive Social Security benefits in England. He had no income. He lived with his partner (S) in her one bedroom flat. She worked part time in a supermarket.
- [36] As to the Claimant's health, the medical records disclose, without any particular detail, that before the relevant events the Claimant suffered from previous alcohol dependency and severe depression with suicidal ideation. The Claimant's past medical notes from his GP and hospital/s were not provided to the court.
- [37] On the 3rd of August 2019 the Claimant attended the Whittington hospital who investigated and diagnosed an acute kidney injury as a result of sepsis caused by a dog bite 2 months before. The Claimant had inpatient care including dialysis. I am not wholly clear as to his date of discharge, it was probably the 24th of August 2019. However, from that date until the 11th of December 2019 he was provided with routine scheduled dialysis three times a week at the Mary Rankin Centre, together with free transport to and fro.
- [38] On the 30th of October 2019 a tunnel line operation was carried out to facilitate the scheduled kidney dialysis.
- [39] At page 149 of bundle 2 is a clinical note from the Defendant to the Claimant's GP dated 30th of October 2019. This recorded the presentation in August 2018 (a typing error for 2019). It also recorded, as I understand it, a past medical history of severe depression with suicidal ideation, alcohol dependency and anxiety. The letter recorded that in clinic the Claimant had broken down in tears and become highly anxious, despite constant reassurance. The Claimant was overwhelmed with fear about the minor operation to insert a line to facilitate dialysis. Doctor Hussain, a renal transplant consultant, recommended some counselling to the GP as part of his own going care.
- [40] On the 4th of November 2019 the Defendant's clinical notes show that the Claimant attended A & E complaining of vomiting and nausea four times a day for the last three weeks, shortness of breath, suicidal thoughts and urinary symptoms. The treatment given was a range of drugs.
- [41] The Claimant himself asked Dr. Iqbal (a consultant in the Defendant's Mary Rankin Centre) in November 2019 whether the Dr. would write to the Home Office to report that he was *too sick* to report regularly to the Home Office in Westminster. The

Defendant did send a letter dated 12 November 2019 to the Claimant's immigration representatives setting out his dialysis.

- [42] In her witness statement (paragraph 6) Dr. Goodlad informed the court that in early December 2019 the Defendant's overseas visitors team (OVT) ascertained that the Claimant was chargeable in advance under the *National Health Service (Charges to Overseas Visitors) Regulations 2015*. Henceforth I shall call those "the Regulations". Doctor Goodlad understood that to mean that the Claimant was chargeable for treatment that was not an immediately necessary service or an urgent service. In the light of that information Dr. Goodlad asserted that her colleague, Dr. Cross, took the decision that the Claimant was not entitled to receive elective, pre booked dialysis without advance payment and informed the Claimant of that decision on the 11th of December. Dr. Cross reassured the Claimant that he could access NHS services that were immediately necessary or urgent through the A & E department. A letter was sent as a result of that consultation. In it Dr. Cross wrote to the Claimant's GP as follows:

"it is my sad duty to inform... that he is not entitled to NHS treatment and that he is, however, entitled to emergency treatment by presenting to an emergency department... he reported that he has lived illegally in the UK for many years but suggested that he had an active application for leave to remain which has been considered by the Home Office. I have accepted this and asked him to forward information to the overseas team and I have given him the generic email address... and provided them with information that he is a legal resident in the UK so that an assessment of his entitlement to NHS services is made clear."

"I have explained that from this point onwards and in retrospect the treatment he has received while not being entitled to NHS treatment is chargeable and subsequent NHS elective sessions will be chargeable. I would be happy to hear from the overseas team to confirm or refute whether he has the right to remain."
(My underlining).

- [43] In her witness statement of May 2021, Dr. Cross explained

"so I took the clinical decision that the Claimant should not receive regular scheduled dialysis at a designated renal unit without upfront payment because it was not an immediately necessary or urgent service. Rather I advised him to attend any any department... in order to access treatment as needed. At the time of that decision the Claimant's residual renal function was significant: his 24 hour residual urine volume was 1015ml in September 2019 and calculated creatinine clearance was 12.33 ml's per minute (normal > 60 mls per minute, standard UK dialysis start 8 mls per minute). This indicated sufficient residual kidney function to mean that the Claimant did not require three times weekly haemodialysis; his biochemical markers were safe and stable. We routinely consider residual kidney function in prescribing an appropriate dose of dialysis.

7. There is no risk that having less frequent dialysis sessions would cause a deterioration in the Claimant's residual kidney function (indeed clinically the opposite is true as the process of dialysis often hastens the loss of residual kidney function and we deliberately tailor dose/ frequency of dialysis taking into account residual kidney function). Neither was it the case that having regular scheduled dialysis sessions would improve his kidney function. Dialysis does the work that the failing kidneys can no longer do, rather than improving kidney function. The decision was made to provide the Claimant with treatment as needed and to do so via A&E, which would allow an assessment of his need

for treatment. This seemed to be an appropriate way of meeting the requirements of the regulations from a clinical perspective.” (My underlining).

- [44] Stopping there, it is clear to me from the letter itself that as at 11 December 2019 Dr. Cross did not have sufficient information about the Claimant’s immigration status to make a “relevant time” decision. She was asking the OVT (overseas visitors team) for information. I shall explain that term below.
- [45] The Claimant visited A & E on the 12th of December 2019, his blood tests were safe, severe depression and suicidal ideation were noted but no dialysis was given. That was a clinical decision.
- [46] On the 16th of December 2019 the Claimant presented at A & E complaining of weakness vomiting and itching but after blood tests no dialysis was given. That was a clinical decision.
- [47] On the 8th of January 2020 the Claimant visited A & E complaining of 12 hours of vomiting, migraine and fatigue. X-rays showed his lungs were normal and he was given dialysis after blood tests and examination. He was advised to attend every one to two weeks. That was a clinical decision.
- [48] On the 20th of January 2020 the DoW asked the Defendant why it was withholding scheduled treatment and asked for details of their decision on the Claimant’s estimated leave date (from England).
- [49] On the 24th of January 2020 the Claimant attended A & E. I note here that he had not attended for 16 days. He complained of fever, cough and itching. X-rays showed his lungs were clear. His blood tests showed his potassium and urea were satisfactory, his kidney function was borderline and it was noted that he was not eligible for routine dialysis but that he needed to attend every one to two weeks to flush the line and to check his bloods.
- [50] On the 31st of January 2020 the Claimant attended A & E. His complaints included vomiting, itching and migraine. Doctor Goodlad examined him and noted that the Claimant had considerable residual renal function and required periodic dialysis to avoid adverse health consequences in the short to medium term. In her witness statement (at paragraph 12) Dr. Goodlad stated that she did not consider that the Claimant had an urgent need for dialysis because his levels of potassium, creatinine and urea were all within acceptable ranges. However, the Claimant described experiencing uraemic symptoms, predominantly itching, nausea and headaches, which he said *did not* noticeably improve with dialysis. He complained of feeling low in mood and sometimes suicidal. She noted considerable residual renal function but that the Claimant was not “keeping well” without any dialysis at all. She advised dialysis on that day. She noted that the Claimant should be billed for dialysis and would not be able to pay the bill. She stated (at paragraph 13) that she noted that the inability to pay was *not* a reason not to provide the treatment which was required to keep the Claimant safe and well. She advised the Claimant that he was free to attend A & E at any time if he felt unwell. She advised him to come to A & E at least weekly so that they could monitor his bloods and blood pressure and ensure his line remained clear and sterile. She suggested attending on Wednesday each week because that tended to

be a quieter day and he would hopefully be seen more quickly. She reassured the Claimant that if he needed dialysis because of the blood tests or his symptoms it would be given to him. She also gave the Claimant a prescription for anti-hypertension medication. Also on that day he was referred to the mental health service liaison team again. She noted that they found his presentation to be similar to his presentation back in November 2019.

- [51] A standard form relating to each OV's estimated date for leaving England was completed by Dr. Goodlad on 31st of January 2020, in which the box was ticked indicating that the hospital understood that the patient was not expected to leave the UK for at least six months "or at all" and noting:

"having made the appropriate diagnostic into investigations, I intend to give urgent treatment which is not immediately necessary to save the patient's life but cannot wait until the patient can leave the UK. If the patient's ability to leave the UK changes I will reconsider my opinion." (My underlining).

- [52] Bundle six was provided by the Defendant as a result of the Claimant's subject access request. That contains some internal documents from the Defendant showing that after the intervener (DoW) contacted the Defendant, its overseas visitors manager corresponded with the DoW in relation to the treatment and the Claimant's status.

- [53] I note here that DoW criticises the blank standard form (not the Defendant) for its relative sparsity but does generally suggest that hospitals should use it. In any event it is clear that the Defendant did fill in the form on the 31st of January.

- [54] On the 3rd of February 2020 the Defendant wrote to the Claimant's GP stating that the Claimant was required to pay for future treatment up front unless it was immediately necessary or clinically urgent.

- [55] On the 9th of February 2020 the Claimant attended A & E complaining of vomiting, migraine and suicidal ideation. Blood tests were taken and he was provided with dialysis. The same occurred on the 19th of February 2020. This continued until late March 2020

- [56] On the 27th of March 2020 the Defendant started to provide the Claimant with twice weekly dialysis at the Mary Rankin Centre. That service has been provided ever since. In her witness statement dated 6 May 2021 Dr. Cross brought the court up to date as to the Claimant's medical story. She stated that the treatment provided to the Claimant since the 27th of March 2020 was identical to that which would be provided to:

"an NHS entitled patient with this level of renal function" (see paragraph 9).

She explained that the move away from the treatment via A & E resulted from the COVID-19 emergency and was designed to protect the patient from the risk associated with the increased pressures on A and E and in accordance with the hospital's decisions to direct non COVID patients away from A & E where possible. She also explained that by 2021 the Claimant's condition had worsened because his 24 hour urine volume had decreased to 446 ml and his creatinine clearance level had

reduced to 5.4 ml's per minute. She informed the court that NHS resources and the Defendant's resources, including those in renal medicine, had been stretched to the limit for over a year by COVID.

The Law

[57] By S.1 of the *National Health Service Act 2006*:

“Secretary of State's duty to promote comprehensive health service

- (1) The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—
 - (a) in the physical and mental health of the people of England, and
 - (b) in the prevention, diagnosis and treatment of physical and mental illness.
- (2) For that purpose, the Secretary of State must exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act.
- (3) The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England.
- (4) The services provided as part of the health service in England must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.” (My underlining).

[58] By S.175:

“175 Charges in respect of non-residents

- (1) Regulations may provide for the making and recovery, in such manner as may be prescribed, of such charges as the Secretary of State may determine in respect of the services mentioned in subsection (2).
- (2) The services are such services as may be prescribed which are—
 - (a) provided under this Act, and
 - (b) provided in respect of such persons not ordinarily resident in Great Britain as may be prescribed.
- (3) Regulations under this section may provide that the charges may be made only in such cases as may be determined in accordance with the regulations.
- (4) The Secretary of State may calculate charges under this section on any basis that he considers to be the appropriate commercial basis.”

[59] By S.39 of the *Immigration Act 2014*:

“39 Related provision: charges for health services

- (1) A reference in the NHS charging provisions to persons not ordinarily resident in Great Britain or persons not ordinarily resident in Northern Ireland includes (without prejudice to the generality of that reference) a reference to—
 - (a) persons who require leave to enter or remain in the United Kingdom but do not have it, and
 - (b) persons who have leave to enter or remain in the United Kingdom for a limited period unless that leave was granted by virtue of residence scheme immigration rules.
- (2) The “NHS charging provisions” are—
 - (a) section 175 of the National Health Service Act 2006 (charges in respect of persons not ordinarily resident in Great Britain);”

[60] By the *2015 Regulations*:
Reg 2:

Interpretation

“overseas visitor” means a person not ordinarily resident in the United Kingdom;

“relevant services” means accommodation, services or facilities which are provided, or whose provision is arranged, under the 2006 Act other than—

(a) primary medical services provided under Part 4 (medical services);

(b) primary dental services provided under Part 5 (dental services);

(c) primary ophthalmic services provided under Part 6 (ophthalmic services); or

“treatment the need for which arose during the visit” means—

(a) diagnosis of symptoms or signs occurring for the first time after the overseas visitor's arrival in the United Kingdom; or

(b) treatment, provided that the overseas visitor has not travelled to the United Kingdom for the purpose of seeking that treatment, which in the opinion of a registered medical practitioner or registered dentist employed by or providing services to the [relevant body] is required promptly for a condition which arose, or became acutely exacerbated, after the overseas visitor's arrival, or which, but for the treatment, would be likely to become acutely exacerbated,

which cannot wait until the overseas visitor can reasonably be expected to return to the overseas visitor's country of ordinary residence.”

(My underlining).

[61] By Reg 3:

“3 Obligation to make and recover charges

(1) Where the condition specified in paragraph (2) is met, a [relevant body] must make and recover charges for any relevant services it provides to an overseas visitor from the person liable under regulation 4 (liability for payment of charges).

(1A) Where the condition specified in paragraph (2) is met, before providing a relevant service in respect of an overseas visitor, a relevant body must secure payment for the estimated amount of charges to be made under paragraph (1) for that relevant service unless doing so would prevent or delay the provision of—

(a) an immediately necessary service; or

(b) an urgent service.”

(2) The condition is that the [relevant body], having made such enquiries as it is satisfied are reasonable in all the circumstances, including in relation to the state of health of that overseas visitor, determines that the case is not one in which these Regulations provide for no charge to be made.

(3) Where more than one relevant body is to provide relevant services to an overseas visitor, each relevant body must secure the advance payment sum in respect of each relevant service that it is to provide.

(3A) Where more than one relevant body provides relevant services to an overseas visitor, each relevant body must make and recover the actual charge in respect of each relevant service that it provides.

(4) A relevant body that makes and recovers a charge in accordance with paragraph (1) or secures payment in accordance with paragraph (1A) must give or send to the person making the payment a receipt for the amount paid.

(4A) In making and recovering an actual charge from a person in respect of a relevant service, a relevant body must—

(a) deduct any advance payment sum secured by the relevant body from that person in respect of that relevant service; and

(b) refund any amount by which an advance payment sum secured by the relevant body from that person in respect of that relevant service exceeds the amount of the actual charge that person is liable to pay.

(5) Subject to paragraph (6), where—

- (a) a [relevant body] has determined that an overseas visitor is exempt from being charged for relevant services under these Regulations, except where the overseas visitor is exempt from being charged by virtue of—
- (i) regulation 10 (immigration health charge);
 - (ii) regulation 11 (overseas visitors who have made applications for entry clearance or leave to remain prior to the commencement of the immigration health charge); . . .
 - (iii) regulation 25(3) (family members of overseas visitors—children born to a parent exempt under regulation 10 or 11); [or]
 - [iv] regulation 14 (reciprocal health care agreements);]
- (b) the overseas visitor has received relevant services from a [relevant body] as part of a course of treatment; and
- (c) prior to the course of treatment being completed, a [relevant body] has determined that the overseas visitor is no longer exempt from being charged for relevant services under these Regulations, a [relevant body] may not make and recover charges under paragraph (1) in respect of relevant services provided as part of that course of treatment during a period where the overseas visitor has remained in the United Kingdom without absence.

(6) Paragraph (5) does not apply where a [relevant body] has determined that a person is exempt from being charged for relevant services as a result of that body receiving fraudulent or misleading information.

(7) In this regulation—

“actual charge” means a charge to be made under paragraph (1);

“advance payment sum” means a sum to be secured under paragraph (1A);

“immediately necessary service” means—

(a) antenatal services provided in respect of a person who is pregnant;

(b) intrapartum and postnatal services provided in respect of—

(i) a person who is pregnant;

(ii) a person who has recently given birth; or

(iii) a baby; and

(c) any other relevant service that the treating clinician determines the recipient needs promptly—

(i) to save the recipient's life;

(ii) to prevent a condition becoming immediately life-threatening; or

(iii) to prevent permanent serious damage to the recipient from occurring;

“urgent service” means a service that the treating clinician determines is not an immediately necessary service but which should not wait until the recipient can be reasonably expected to leave the United Kingdom.”

(My underlining).

By reg. 9:

“9 Relevant services exempt from charges

No charge may be made or recovered in respect of any of the following relevant services provided to an overseas visitor—

(a) accident and emergency services, but not including any services provided—

(i) after the overseas visitor has been accepted as an in-patient at a hospital; or

(ii) at an outpatient appointment;

[(aa) services provided as part of the telephone advice line commissioned by a clinical commissioning group or the National Health Service Commissioning Board;]

(b) . . .

(c) family planning services;

(d) services provided for the diagnosis and treatment of a condition listed in Schedule 1;”

(My underlining).

Having read Schedule 1 it is clear that kidney disease and dialysis are not automatically free services. They are charged in advance services unless the INS or US categorisation applies. However, as Reg. 9 states, A & E services are always free to all, but not so for many of the services provided in the hospital after A & E. Inpatient services and outpatient appointments are chargeable in advance unless they are categorised as INS or US. So dialysis after A & E assessment, without inpatient admission or outpatient appointment, is probably chargeable in arrears, not in advance. However I would need to hear more evidence on those terms and procedures to get a clearer view on those terms.

The Guidance

[62] The Department of Health and Social Care issued main guidance on applying the Regulations. The relevant document, which has been updated but is substantially the same as before, was issued in February 2020. I shall refer to it as “the Guidance”.

[63] **Non urgent services:** in clause 5 the Guidance stated that:

“5. When charges apply, a relevant body must make and recover charges from the person liable to pay for the services provided to the overseas visitor. Since 23 October 2017 relevant bodies are required to recover these charges in full in advance of providing them, unless doing so would prevent or delay the provision of immediately necessary or urgent services. Care which is clinically considered non-urgent and can await the overseas visitor's leaving the UK must be paid for in full before it is provided.”

Therefore OV's are deprived of non urgent NHS services for which they cannot pay.

[64] **Human Rights:** In clause 18 the Guidance stated that:

“18.A relevant body also has human rights obligations, so chargeable treatment which is considered by clinicians to be immediately necessary must never be withheld from an overseas visitor or delayed, even when that overseas visitor has indicated that they cannot pay. This does not mean that the treatment should be provided free of charge. Charges will still apply, and, if not yet recovered, should be pursued after the treatment is provided. Treatment which is not immediately necessary, but is nevertheless classed as urgent by clinicians, as it cannot wait until the overseas visitor can be reasonably expected to leave the UK, should also be provided without delay regardless of the patient's ability to pay. Every effort should be made to obtain payment or a deposit in the period before treatment starts.”

[65] **Overseas Visitors:** Part 8 focussed on OV's. The introduction stated:

“This chapter gives important advice on the safeguards that relevant bodies must employ to protect the lives of overseas visitors who are not exempt from charges under the Charging Regulations, and guidelines on how relevant bodies should handle such people without the resources to pay, including when to withhold treatment.”

[66] **Immediately Necessary:** The Guidance stated:

“What is immediately necessary, urgent and non-urgent treatment?”

8.3 Only clinicians can make an assessment as to whether a patient's need for treatment is immediately necessary, urgent or non-urgent. In order to do this, they may first need to make initial assessments based on the patient's symptoms and other factors, and conduct

further investigations to make a diagnosis. These assessments and investigations will be included in any charges. (My underlining).

“Immediately necessary treatment

8.4 Immediately necessary treatment is that which a patient needs promptly:

- to save their life; or
- to prevent a condition from becoming immediately life-threatening; or
- to prevent permanent serious damage from occurring.”

[67] **Urgent Treatment:** The Guidance stated:

“Urgent treatment

8.7 Urgent treatment is that which clinicians do not consider to be immediately necessary, but which nevertheless cannot wait until the person can be reasonably expected to leave the UK. This means that the longer a patient is expected to remain in the UK, the greater the range of their treatment needs that are likely to be regarded as urgent. If the person is unlikely to leave the UK for some time (which will be the case for some undocumented migrants), treatment which clinicians might otherwise consider non-urgent (e.g. certain types of elective surgery) is more likely to be considered by them as urgent. It may not always be clear when a person can reasonably be expected to leave the UK. See paragraphs 8.18-8.23 for information on how to deal with these cases.

8.8 Clinicians may base their decision as to whether treatment can reasonably wait until the expected date by which the patient can leave the UK on a range of factors, including:

- the pain or disability a particular condition is causing,
- the risk that delay might mean a more involved or expensive medical intervention being required, or
- the likelihood of a substantial and potentially life-threatening deterioration occurring in the patient’s condition if treatment is delayed until they leave the UK.”

[68] **Non urgent treatment:** The Guidance stated:

“Non-urgent treatment

8.12 Non-urgent treatment is treatment that can wait until the date a patient can reasonably be expected to leave the UK. Relevant bodies must not provide non-urgent treatment until the estimated full cost of treatment has been received.”

[69] **OVs leaving the UK:** The Guidance stated:

“How to determine when an overseas visitor patient can reasonably be expected to leave the UK

8.18 For treatment which is not immediately necessary, it is the role of the OVM to establish when a patient can reasonably be expected to leave the UK. Clinicians will need to know this information in order to decide if the patient's need for treatment is urgent or if it can safely wait until they leave the UK.”

(My underlining).

So the role of deciding the relevant timescale is give to the OVM not the clinician.

[70] **Undocumented migrants:** The Guidance stated:

“Undocumented migrants

8.21 For undocumented migrants, including failed asylum seekers (some of whom will be chargeable), the likely date by which the person can reasonably be expected to leave the UK may be unclear, and will have to be assessed on a case-by-case basis. Those for whom there is no viable place of return, for example because there are travel or entry clearance restrictions in their country of origin, or for whom there are other conditions beyond their control preventing their departure, should not reasonably be expected to leave the UK, until such issues are resolved.

8.22 For some cases relating to undocumented migrants, it will be particularly difficult to estimate the date at which they can be reasonably expected to leave the UK. Relevant bodies may wish to estimate that such patients will remain in the UK initially for six months, and the clinician can then consider if treatment can or cannot wait for six months, bearing in mind the definitions of urgent and non-urgent treatment given above. However, there may be circumstances when the patient is likely to remain in the UK longer than six months, in which case a longer estimate can be used.” (My underlining).

[71] **Reassessment:** The Guidance stated:

“Re-assessing urgency of treatment decisions (applies to all chargeable patients)

8.23 Where a clinician has decided that the need for treatment is non-urgent this should be reassessed if the patient informs the relevant body that their return date has been postponed for valid reasons. It should also be reassessed if the patient’s medical condition unexpectedly changes. On being told that their need for treatment has been found to be non-urgent, and will therefore not proceed without advance payment, patients should be informed that they should present again for a reassessment of the urgency of their treatment if their condition changes. Alternatively, patients’ circumstances may require regular follow-up by clinicians.” (My underlining).

[72] **Limits on treatment for OVs:** The Guidance stated:

“What limits should be placed on treatment?”

8.24 While urgency of treatment is a matter of clinical judgement, this does not mean that treatment should be unlimited; there may be some room for discretion about the extent of treatment and the time at which it is given. In many cases, a patient undergoing immediately necessary treatment may be able to be stabilised, allowing them to be safely discharged and giving them time to return home for further treatment rather than incurring further avoidable charges. This should be done wherever possible, unless ceasing or limiting treatment would precipitate deterioration in the patient’s condition.” (My underlining).

The Operational Guidance

[73] Subsidiary to the Guidance, in January 2021 the Department of Health issued Operational Guidance or Framework Guidance to supplement the main guidance set out above.

[74] At section 5 the following Operational Guidance (the OG) is given to NHS Trusts:

“5.3 Clinician assessments of overseas visitor patients

It is the clinician’s role to provide appropriate healthcare for patients and make decisions on their treatment based on their clinical needs. The charging regulations do not change that.

Once the OVM/patient-facing administrative team has established that the patient is chargeable and the date by which they could reasonably be expected to have left the UK,

it is the responsibility of clinicians to decide whether the patient's treatment is immediately necessary, urgent or non-urgent.

Only clinicians can make an assessment of the urgency of treatment; the final decision lies with the lead treating clinician. Immediately necessary treatment is that which a patient needs promptly to:

- save their life
- prevent a condition from becoming immediately life-threatening
- prevent permanent serious damage from occurring

Urgent treatment is that which clinicians do not consider to be immediately necessary, but which nevertheless cannot wait until the person can be reasonably expected to leave the UK. This means that the longer a patient is expected to remain in the UK, the greater the range of their treatment needs that are likely to be regarded as urgent.

If the person is unlikely to leave the UK for some time (which will be the case for some undocumented migrants), treatment which clinicians might otherwise consider non-urgent (for example, certain types of elective surgery) is more likely to be considered by them as urgent. It may not always be clear when a person can reasonably be expected to leave the UK.

Clinicians may base their decision as to whether treatment can reasonably wait until the expected date by which the patient can leave the UK on a range of factors, including:

- the pain or disability a particular condition is causing
- the risk that delay might mean a more involved or expensive medical intervention being required
- the likelihood of a substantial and potentially life-threatening deterioration occurring in the patient's condition if treatment is delayed until they leave the UK

Non-urgent treatment is routine treatment that can wait until the date a patient can reasonably be expected to leave the UK.

The clinician will need to make initial assessments based on the patient's symptoms and other factors and to conduct further investigations to make a diagnosis. Although these initial assessments and investigations will be included in any charges (unless an exemption applies), they cannot be withheld even if a payment for treatment has not been received upfront for the cost of the assessment.

While urgency of treatment is a matter of clinical judgement, this does not mean that treatment should be unlimited – there may be some room for discretion about the extent of treatment and the time at which it is given. In many cases, a patient undergoing immediately necessary treatment may be able to be stabilised, allowing them to be safely discharged and giving them time to return home for further treatment rather than incurring further avoidable charges. This should be done wherever possible, unless there is a risk that ceasing or limiting treatment would cause deterioration in the patient's condition.

The clinical team or department should inform the OVM/patient-facing administrative team if a patient is receiving a particular treatment that is exempt from charges, for example if a patient is undergoing diagnosis or receiving treatment for a sexually transmitted disease (see Chapter 1 of the main guidance (<https://www.gov.uk/government/publications/overseas-nhs-visitors-implementing-the-charging-regulations>) for the full list).

If a clinician does become aware that a person who has not been identified as chargeable is not ordinarily resident in the UK, they should notify the OVM/patient-facing administrative team. The OVM/patient-facing administrative team can then work with the patient to confirm whether they are eligible for free care and enable the patient to make informed decisions about their treatment and travel plans.

To record their assessment decision, clinicians should complete their section of the clinician patient assessment form

(<https://www.gov.uk/government/publications/overseas-nhs-visitors-framework-to-support-identification-and-upfront-charging/upfront-charging-operational-framework-to-support-identification-and-charging-of-overseas-visitors#Clinician-patient-assessment-form>) and sign and date it.

This form includes 4 options, which set out whether treatment:

- is immediately necessary
- is urgent
- is non-urgent – and therefore it is not necessary to provide treatment unless payment is made in advance
- requires further investigation before assessment of urgency can be made

A series of clinical case studies is set out in Section 9 of this guidance to support clinicians when making decisions about whether the care they recommend is urgent or immediately necessary.

Patients who need to be monitored after discharge

The clinician will decide on a case-by-case basis when a patient is fit for discharge and the level of monitoring required post-discharge. As part of the discharge decision, the patient should be assessed for their clinical fitness to travel.

There should be an approved discharge planning process for managing the discharge/transfer of patients, including arrangements for clinically necessary post-discharge monitoring that is implemented and kept under review. The costs to the patient of that on-going monitoring must be made clear to the patient.”

(My underlining).

I note that “initial” assessments and investigations are mentioned in this guidance.

[75] In the Operational Guidance there is an interesting and partly relevant case study:

“11.3 Case study 3: dialysis

A chargeable patient attends the ED presenting with acute renal disease requiring dialysis 3 times a week:

- following clinical assessment and admission, the consultant advises that the patient requires urgent dialysis to prevent their illness from causing any further renal damage or risk to life
- the OVM/patient-facing administrative team identifies the patient as chargeable and asks the consultant to complete a request for advice from dentist/Dr. form. The consultant determines that the treatment, and ongoing dialysis programme, is immediately necessary
- as it is needed to prevent the patient’s condition from becoming life-threatening
- the OVM/patient-facing administrative team informs the patient that they should pay for their treatment, however the provider will not withhold treatment should they find themselves unable to pay

Overseas visitor regulations: considerations

- only clinicians can make an assessment as to whether a patient’s need for treatment is immediately necessary, urgent or non-urgent
- despite dialysis treatment being planned and routine, denial of this treatment would result in serious worsening of the patient’s condition within a matter of hours. Therefore the treatment should be considered immediately necessary
- as treatment is immediately necessary the date on which the patient can reasonably be expected to return home is irrelevant”

This useful example related to a patient with a kidney condition/disease for which treatment was needed to prevent serious worsening of the patient’s renal condition,

perhaps within hours. In the Claimant's case the kidney damage was caused by historic sepsis. In the Claimant's case the clinical premise is that dialysis is provided to assist with symptoms, not to prevent further kidney damage. This distinction shows how fact sensitive every case is.

Terminology

[76] In the rest of this judgment, using the terminology set out in the Regulations, I shall refer to treatment provided as an immediately necessary service as "INS" treatment, and to treatment provided as an urgent service as "US" treatment.

[77] The paragraphs of the Guidance will be referred to as "G 8.8" etc.

Submissions

[78] The Claimant and first intervener submit that all patients are equal when they come before the NHS. US treatment is either needed or it is not. No different standard of treatment or quality of treatment can or should be provided to an OV patient when compared to a person ordinarily resident in England (an OR patient). An OV should not be offered any "inferior" modality of treatment to an OR with the same condition.

[79] Further the Claimant submitted that when interpreting the Regulations the words "urgent service" are a mere "label" and do not have any effect on the categorisation of the treatment which is to be provided free as "US". Only the words in Regulation 3(7)(c) after the title may determine the categorisation.

[80] So the Claimant submits that when Dr. Cross decided to withdraw scheduled dialysis on 11.12.2019, solely because the Claimant was OV, as the Defendant had just found out, and expressly because he was OV, and on the basis that elective treatment was not available for free to OVs, the Defendant was (1) taking into account a matter which she should not have taken into account and (2) providing a different service with a different standard of care to an OV patient from that which it would have provided to an OR patient and that was unlawful because the decision was not made on clinical grounds but instead was made on status grounds or policy grounds. In effect the submission was that the Defendant discriminated against the OV Claimant. She mistakenly thought that scheduled dialysis was not, by definition, a US. She mistakenly thought that only A & E services were free to OVs.

[81] The Claimant also submitted that Dr. Cross omitted to take into account a matter relevant to the decision: that the Claimant would be in England for a longish time on the information reasonably available. So she overlooked it altogether or she misdirected herself as to the "relevant time" criterion.

[82] The Defendant submitted that the choice of treatment and all of the details thereof, place, time, pathway, tests, costs, waiting and all other matters, are for the clinicians and are not reviewable by this court. In addition the Defendant submitted that it *did* provide this OV patient (the Claimant) with dialysis when he needed it, as a US service, so it matters not whether they changed the method or plan or location or timing for that supply. The details are a matter for the clinicians. Further that the wording of the letter on 11 December 2021 albeit poor did not reflect what was actually being offered.

- [83] The Secretary of State submitted that the NHS provides US treatment and non US treatment. Refusing to provide non US treatment will involve causing a level of suffering and that was foreseen by Parliament. That is inherent in the legislation.
- [84] So long as the Claimant was provided with the US treatment he needed it did not matter that an OR could or would have been provided with a different or better treatment plan or method. The legislation did not prevent that. On the contrary the legislation did itself discriminate between ORs and OVs. OVs are not entitled to non-urgent treatment for free and if they cannot pay for it they are deprived of it altogether. In addition, the NHS can provide (treatment plus) which is over and above the base necessary level if they are willing and able, but they must provide US (standard treatment) to an OV if the relevant timescale requires US treatment.
- [85] DoW provided evidence in the form of various case studies seeking to show that the correct interpretation of US under the Regulations has regularly been misunderstood by clinicians. 8 case studies were provided and each, say the DoW, showed delays in the provision of urgently needed treatment by various NHS hospitals to various persons with undetermined status who were OV. Miss Miller of DoW suggested that these showed that eligibility for US treatment is regularly being misunderstood by clinicians. She asserted that clinically needed treatment which was urgent was being refused on various improper grounds: OV status, lack of up front payment and lack of consideration of the patient's "relevant timescale" to stay in the UK pending determination of their immigration status applications. She asserted that many clinicians simply think (wrongly) that elective surgery or treatment is not to be provided to OVs in any circumstances without up front payment.
- [86] The DoW submitted that there was only one factor for a clinician to consider when determining whether treatment was US, and that was "whether the service should not wait until the OV can reasonably be expected to leave the UK". That the "relevant timescale" decision (as I call it) was to be made by the Trust's OVM (overseas visitor manager), and the DoW submitted that it would not be lawful for the clinician to take into account non clinical factors when making the treatment decision. Particularly if they had the effect that an OV would be expected to endure a greater risk of harm than an OR due to the delay in the provision of service.

Case Law

- [87] I start by taking into account the guidance given by Lord Diplock in *Council of Civil Service Unions v Minister for the Civil Service* [1985] AC 374, on the scope of judicial review (p408F):

“To qualify as a subject for judicial review the decision must have consequences which affect some person (or body of persons) other than the decision-maker, although it may affect him too. It must affect such other person either:

- (a) by altering rights or obligations of that person which are enforceable by or against him in private law; or
- (b) by depriving him of some benefit or advantage which either (i) he had in the past been permitted by the decision-maker to enjoy and which he can legitimately expect to be permitted to continue to do until there has been communicated to him some rational grounds for withdrawing it on which he has been given an opportunity to comment; or (ii) he has received assurance from the decision-maker will not be withdrawn without giving him first an opportunity of advancing reasons for contending that they should not

be withdrawn. (I prefer to continue to call the kind of expectation that qualifies a decision for inclusion in " class (b) a "legitimate expectation" rather than a "reasonable expectation," in order thereby to indicate that it has consequences to which effect will be given in public law, whereas an expectation or hope that some benefit or advantage would continue to be enjoyed, although it might well be entertained by a "reasonable" man, would not necessarily have such consequences. The recent decision of this House in *In re Findlay* [1985] A.C. 318 presents an example of the latter kind of expectation. "Reasonable" furthermore bears different meanings according to whether the context in which it is being used is that of private law or of public law. To eliminate confusion it is best avoided in the latter.)

For a decision to be susceptible to judicial review the decision-maker must be empowered by public law (and not merely, as in arbitration, by agreement between private parties) to make decisions that, if validly made, will lead to administrative action or abstention from action by an authority endowed by law with executive powers, which have one or other of the consequences mentioned in the preceding paragraph. The ultimate source of the decision-making power is nearly always nowadays a statute or subordinate legislation made under the statute; but in the absence of any statute regulating the subject matter of the decision the source of the decision-making power may still be the common law itself, i.e., that part of the common law that is given by lawyers the label of "the prerogative." Where this is the source of decision-making power, the power is confined to executive officers of central as distinct from local government and in constitutional practice is generally exercised by those holding ministerial rank."

- [88] I also take into account the guidance of Lord Phillips in *R. (Q) v Secretary of State for the Home Department* [2003] EWCA Civ 364; [2003] 3 W.L.R. 365, [2004] Q.B. 36 on abstaining from reviewing the merits of a decision:

"112. The common law of judicial review in England and Wales has not stood still in recent years. Starting from the received checklist of justiciable errors set out by Lord Diplock in *Council of Civil Service Unions v Minister for the Civil Service* [1985] AC 374, the courts, as Lord Diplock himself anticipated they would, have developed an issue-sensitive scale of intervention to enable them to perform their constitutional function in an increasingly complex polity. They continue to abstain from merits review—in effect, retaking the decision on the facts—but in appropriate classes of case they will today look very closely at the process by which facts have been ascertained and at the logic of the inferences drawn from them. Beyond this, courts of judicial review have been competent since the decision in *Anisminic Ltd v Foreign Compensation Commission* [1969] 2 AC 147 to correct any error of law whether or not it goes to jurisdiction; and since the coming into effect of the Human Rights Act 1998, errors of law have included failures by the state to act compatibly with the Convention."

- [89] So for example in *R v Cambridge Health Authority* [1995] 1 WLR 898, the Court of Appeal refused to get involved in determining how a health authority allocated its sparse funds and the decision not to fund experimental treatment (p902H) in the USA for a very seriously ill young claimant was one for the authority to make. At p 905B Lord Bingham ruled that the courts are not arbiters as to the medical merits of cases of this kind.

"Were we to express opinions as to the likelihood of the effectiveness of medical treatment, or as to the merits of medical judgment, then we should be straying far from the sphere which under our constitution is accorded to us. We have one

function only, which is to rule upon the lawfulness of decisions. That is a function to which we should strictly confine ourselves.”

I take this guidance into account below.

- [90] In *R (Burke) v GMC* [2006] QB 273 (Court of Appeal), the claim concerned a man with a degenerative disease who objected to the published GMC advice about withdrawing nutrition for seriously ill patients in their final weeks of life. He was a long way from that untimely and fearful occurrence but on the medical evidence it was inevitable. He did not wish in future for a doctor to turn off his life support. Guidance was given that the courts should not be used as a general advice centre divorced from the facts of any case: per Lord Phillips MR at p293 C. Further at P293 para 21 Lord Phillips referring to the judgment of Lord Bridge *Gillick v West Norfolk* [1986] AC 112 @ 193-194, warned of courts grappling with issues divorced from the facts and announcing propositions without full appreciation of the implications thereof on those in practice in particular where ethical questions are raised. The court must confine itself to considering whether propositions of law in departmental guidance are erroneous.
- [91] In *R (Zoolife) v Secretary of State* [2007] EWHC 2995, guidance was given on purely academic judicial review by Silber J:

“[35] Similar principles have been applied in the Administrative Court, for example, by Munby J in *R (Smeaton on Behalf of the Society for the Protection of Unborn Children) v Secretary of State for Health (Schering Health Care Ltd and Family Planning Association as Interested Parties)* [2002] EWHC 610 (Admin) and [2002] EWHC 886 (Admin), [2002] 2 FLR 146, at 244, [420] (‘the facts remain that the court – including the Administrative Court – exist to resolve real problems and not disputes of merely academic significance’) and by Davis J in *British Broadcasting Corporation v Sugar* [2007] EWHC 905 (Admin), [2007] 1 WLR 2583, at 2606, [70] (‘to grant remedies by reference to a decision made in now outmoded circumstances seems to me to be an arid and academic exercise. It is not something that, as an Administrative Court judge, I would have been minded to do’). Although these statements indicate that if an issue is academic, the court cannot determine it, these statements must be subject to what was said in *R v Secretary of State for the Home Department ex parte Salem* [1999] AC 450 and which has, as far as I can discover, not been disapproved of or qualified in any manner in any later case.

[36] In my view, these statements show clearly that academic issues cannot and should not be determined by courts unless there are *exceptional* circumstances such as where two conditions are satisfied in the type of application now before the court. The first condition is in the words of Lord Slynn of Hadley in *Salem* (supra) that ‘a large number of similar cases exist or anticipated’ or at least other similar cases exist or are anticipated and the second condition is that the decision in the academic case will not be fact-sensitive. If the courts entertained academic disputes in the type of application now before the court but which did not satisfy each of these two conditions, the consequence would be a regrettable waste of valuable court time and the incurring by one or more parties of unnecessary costs.”

I take from this the guidance on how to approach potentially academic judicial review claims.

- [92] In *R (A) v Sec of State for Health [2009]* EWCA Civ 225, the Court of Appeal were determining an appeal as to the status of a person who might have been an OV or an OR and a judicial review of the Defendant's guidance on when free healthcare could be given to an OV. The previous legislative provisions were considered. The 2015 Regulations did not exist back then. There was an informal discretionary system for granting free care for OVs. Per Ward LJ at paras 72 et seq:

“72 It would seem, therefore, that under the statutory scheme the hospital is required to charge overseas visitors but it does have a discretion it can exercise: the hospital can choose to treat or it can choose not to treat those who cannot or will not pay. The Secretary of State accepts and seeks a declaration to reinforce the discretion to treat for example those in immediate need. The claimant accepts that at the extreme end of the spectrum, if the hospital is faced with a wealthy overseas visitor who has no urgent need for treatment and could at any time return home and be treated there, then it would clearly not be very sensible if (faced with a refusal to pay charges) the trust have to provide the treatment and then to try to pursue the individual in their home jurisdiction. In that instance the hospital could legitimately conclude that it was not necessary to provide services for that particular patient. The group of failed asylum seekers here are at the other end of the spectrum, being unable to pay and not being able to return home. 73 As for the guidance, the issue is whether this guidance is sufficiently clear and unambiguous in the advice it gives to help decide whether to treat or not to treat an individual who, although chargeable in principle, does not in fact have the resources to pay for that treatment and who reasonably requires to be treated in the United Kingdom rather than returning to his country of origin for such treatment, either because he is not currently in a position to return at all, or because there is such a sufficiently pressing need for the treatment that there would be significant detriment to his health if that treatment had to wait his travel.

74 The guidance divides treatment into three categories. The first is “immediately necessary treatment”, referred to at para 3.1 but further defined in para 9 which makes it clear:

“trusts need to treat patients in need of immediately necessary care regardless of their ability to pay. This may be because their condition is life-threatening, or because if treatment is not given immediately it will become life-threatening, or because permanent serious damage will be caused by any delay . . . Where immediately necessary treatment takes place and the trust knows that payment is unlikely, treatment should be limited to that which is clinically necessary to enable the patient to return to their own country. This should not normally include routine treatment unless it is necessary to prevent a life-threatening situation. Any charge for such treatment will stand, but if it proves to be irrecoverable, then it should be written off”

This is clear enough in so far as it advises that certain treatment should be given irrespective of the ability to pay for it but it leaves unclear what, if any, investigation should be made as to when the patient is likely to return to his own country so as to be able to decide what limits should be placed on the treatment.

75 The second category is “urgent treatment” which is treatment which is not immediately necessary but cannot wait until the patient returns home.

The advice that is given by the guidance is that when the patient is chargeable the trust should “wherever possible” seek deposits equivalent to the estimated full cost of the treatment in advance of providing any treatment. The problem here is that the guidance is silent on what should happen when it is not possible to provide that deposit. No help is given in the case of those who cannot return home before the treatment does become necessary. What is to happen to the patient who cannot wait? In those respects the guidance is not clear and unambiguous and in so far as it purports to be dealing with a category of patients like those before us, the failed asylum seekers who cannot be returned, it is seriously misleading.

76 As for non-urgent treatment, namely “routine elective treatment which could in fact wait until the patient returned home”, the advice given is that where the patient is chargeable, the trust should not initiate treatment processes (even by putting the patient on a waiting list) until a full deposit has been obtained. The assumption has to be that the patient can return home before that routine elective treatment becomes necessary. Again, it is not clear what should be done for those who have no prospect of returning within a medically acceptable time. There is no suggestion that it may be necessary to treat in those circumstances or even that it may be necessary to investigate the likelihood and length of any undue delay. Once again the guidance is not clear enough.

77 My conclusion is that it is implicit in the guidance that there is a discretion to withhold treatment but there is also discretion to allow treatment to be given when there is no prospect of paying for it. How that discretion is to be exercised may depend on how long the failed asylum seeker will remain at large and the plight of those who cannot return should be identified and clarified in the guidance.

78 Miss Laing concedes on the Secretary of State’s behalf that if the guidance is materially unclear or misleading, then the court should say so. I would now leave it to the parties to put further submissions to the court in writing as to the nature of the relief on the appeal and the cross-appeal which should follow from the conclusions to which I have been driven.

Conclusions

79 The Secretary of State’s appeal will succeed on the first and second issues and, for what it may be worth, against the judge’s refusal to acknowledge that there is a discretion to withhold treatment but the cross appeal is also successful. ...”

- [93] I draw from this judgment that before the 2015 Regulations and Guidance the structure was different and the old guidance was declared unclear on the exercise of the discretion to provide treatment. I should say here that I have not been provided with the background to the creation of the 2015 Regulations. I can make no assumptions on whether the *R(A)* case from 2010 led to the Regulations or not. But I do note the similarity in the categories of case where OV’s could in the past gain discretionary free treatment (INS and US) with the same categories now defined in the Regulations and the new Guidance.
- [94] In *R (A) v Sec of State for Health [2017] EWHC 2815*, the court considered the legislation which divided organ donation recipients into ORs and non ORs roughly. The latter (including OV’s) were very unlikely ever to gain donated organs. Irwin LJ and Haddon-Cave LJ rejected the judicial review application by the Claimant who was in category 2. Irwin LJ ruled that:

“44. In our view, it follows that in that respect the interpretation of Ward LJ must be taken to be correct. It follows that the intention of Parliament in setting the “target duty” for the Secretary of State must have been to stipulate a focus on promotion of health and provision of services for those who have “a legitimate connection with the country”.

53 In the end, the critical point in our judgment is that the power to give directions to NHSBT under section 8 and section 272 of the 2006 Act is not limited by any provision other than section 1 of the Act. We do not accept that the 2005 Directions [are] in conflict with that “target duty”. It is therefore not ultra vires. Since there is no longer any human rights challenge to the Directions, and no rationality challenge, we dismiss the claim for judicial review.”

This is a mere example of legislation where one group is not provided with the same medical service as another group based on resident status.

- [95] When interpreting the regulations I take into account the guidance given in *R (CXF) v Central Bedfordshire Council* [2018] EWCA civ 2852 and [2019] 1 WLR 1862 at 1868: by Leggatt LJ:

“20 The lack of attention to this subject was highlighted by Professor Andrew Burrows in his 2017 Hamlyn Lectures (Thinking about Statutes: Interpretation, Interaction, Improvement). In the first of those lectures Professor Burrows gave a helpful summary of the present English law on statutory interpretation. He showed that the modern emphasis is on a contextual approach designed to identify and give effect to the purpose of the statute: see e.g. *McGuckian v Inland Revenue Comrs* [1997] 1 WLR 991, 999 (Lord Steyn); *R v Secretary of State for the Environment, Transport and the Regions, Ex p Spath Holme Ltd* [2001] 2 AC 349, 397 (Lord Nicholls of Birkenhead); *R (Quintavalle) v Secretary of State for Health* [2003] 2 AC 687, paras 8 (Lord Bingham of Cornhill) and 21 (Lord Steyn). The governing principle was succinctly stated by Toulson LJ in *An Informer v A Chief Constable* [2013] QB 579, para 67, when he said: “Construction of a phrase in a statute does not simply involve transposing a dictionary definition of each word. The phrase has to be construed according to its context and the underlying purpose of the provision”

21 The relevant context of a statutory provision is both internal and external to the statute. The internal context requires the interpreter to consider how the provision in question relates to other provisions of the same statute and to construe the statute as a whole. The external context includes other relevant legislation and common law rules, as well as any policy documents such as Law Commission reports, reports of Parliamentary committees, or Green and White Papers, which form part of the background to the enactment of the statute. When the strict conditions specified by the House of Lords in *Pepper v Hart* [1993] AC 593 are satisfied, reference may also be made to Parliamentary debates as reported in Hansard.”

- [96] There are two cases that have been put before me interpreting the 2015 Regulations or their predecessors and successors. I find some help in *R (SHU) v SSHSC* [2019] EWHC 3569 (Admin). The background was set out at paras 22-41, but at para 129 Justice Foster ruled:

“The policy objective of deterring those with a less strong connection to the UK from travelling to or remaining in the UK, and receiving free health treatment, is plainly

rational and constitutes a legitimate aim. The aim of protecting a finite national service under financial and resource pressure from use by visitors and those who, in general, do not make a permanent contribution to paying for it, is in my judgement clear and proportionate.”

Analysis

The general system

- [97] Taking the case law above into account, it is clear that the legislation and subsidiary legislation sets up a general system which provides for NHS medical treatment which is free to persons who are ordinarily resident (OR) in England.
- [98] The relevant legislation, which has quite a lot of history and has been developed politically over the years, also provides that treatment will be provided by NHS secondary care providers to overseas visitors (OVs) who must pay for it in advance or it will not be provided. I have heard no evidence on the intended or actual costs savings but they were mentioned in the judgment *R (SHU)*. However A & E services are free, maternity services are automatically INS), schedule 1 services are free and there are two clear exceptions to the general system of charging OVs in advance. These are examined below.
- [99] The overview of the general charging system for OVs is this:
- A & E assessment is given for free.
 - Treatment in the hospital at A & E is free.
 - Maternity care and Schedule 1 services are automatically INS.
 - Dialysis is not a Schedule 1 service.
 - When an OV becomes an inpatient, treatment is charged for the services up front (or they are refused if no payment is made), unless they are INS or US.
 - Outpatient appointments are charged up front (or they are refused if no payment is made) unless they are INS or US.
 - Non urgent treatment is charged up front (or it is refused if no payment is made). It is not to be given free at all.

Immediately Necessary Services (INS)

- [100] In Reg. 3(1A) there are two exceptions to the general system set out in the preceding paragraphs. If an OV, on clinical assessment, needs treatment which the clinician categorises as INS then the provision of treatment cannot be delayed until after payment is received. By Reg 3(7) certain types of treatment are automatically placed within the INS category. Those types include maternity services, presumably because of the inherent risks in such situations but I make no finding on that. Other types of treatment require assessment by the clinician using the factors set out in the guidance, before they can be categorised as INS. The factors in summary focus on the need for prompt treatment to: save life; or to avoid the risk of (1) life being lost, or (2) of serious permanent injury or damage occurring. This claim is not concerned with INS treatment.

Urgent Service (US)

- [101] The claim is put on the basis of the Claimant’s asserted need for US treatment on two dates: 11 December 2019 and 31 January 2020. In law, if the service needed in the

relevant timescale is US then no prior payment is required before the service should be started.

[102] The Regulations state that “urgent service” means a service that the treating clinician determines is not an immediately necessary service but which “should not wait until the recipient can be reasonably expected to leave the United Kingdom.” Breaking this categorisation process down and putting it in the context of the Regulations and the Guidance:

- (1) The legislation provides for free A & E assessment and treatment.
- (2) The legislation does not permit an NHS trust or a trust clinician to provide treatment to an OV which in the clinician’s judgment is categorised as a non-US, without obtaining payment in advance.
- (3) The legislation does require an NHS trust or clinician therein to provide treatment which is properly categorised as a US, before payment is received.
- (4) The categorisation assessment of and decision upon what is and is not a US is made by a clinician on the information before him or her. The information can broadly be split into four areas: medical factors, NHS provision factors, relevant timescale and entitlement status.
- (5) The medical factors which the clinician will consider in relation to US treatment should include those in G 8.8: pain or disability which is being or will be caused; the risk that delay may give rise to more involved or expensive treatment being required; the likelihood of a substantial or life threatening deterioration occurring if treatment is delayed until the patient leaves England.
- (6) The NHS provision factors will include staffing, equipment, services, location, and a basket of other systemic matters and strains and calls on NHS services.
- (7) The clinician should presume that on leaving England the relevant medical treatment service will be provided in the patient’s country of destination. Whether in fact that will be provided is a matter for the Home Office not the clinician.
- (8) The decision on US treatment categorisation may need to be delayed for days or weeks for medical investigations and results, partial treatment and the effects thereof and many other clinical or systemic matters too varied and complex to list in this judgment (OG 5.3).
- (9) I consider that the time point when a US categorisation decision is to be made is also a matter for the clinician and depends (in part) on the medical, timescale and system information available at the time. It may be a single decision or an iterative one.
- (10) When the clinician is trying also to consider the relevant timescale, there will either be sufficient evidence before the clinician, provided by the patient and the overseas visitors team (OVT) of the trust, or there will not. The OVT will in due course need to make or will have made reasonable efforts to find out the patient’s leave date, perhaps by contacting the Home Office or his immigration lawyers or both or other sources. If there is inadequate information available to the clinician the US categorisation decision cannot be made. That is the express effect of the words in Reg. 3(2):

“The condition is that the [relevant body], having made such enquiries as it is satisfied are reasonable in all the circumstances, including in relation to the state of health of that overseas visitor, determines...”.

In which case the categorisation decision must be put back and an interim clinical decision made. If after such reasonable efforts, there is still insufficient information, a suggested presumption for the OVT to make is provided in the Guidance for the relevant timescale of a 6 month period (G 8.22).

- (11) When the clinician decides that a US categorisation decision can be made, the clinician must determine whether the treatment is an INS. Only if it is not INS does the clinician then go on to consider whether the treatment is a US.
- (12) When considering whether the treatment or range of treatment options which the patient needs or may need is a US the “relevant timescale” (as I call it) to consider on the day of the US categorisation assessment is from that day until the date on which the patient can reasonably be expected to leave England. So the timescale may be an hour, a day, a week, a month or a year or more depending on the evidence provided to the clinician.
- (13) The greater the relevant timescale, the more opportunity the clinician will have to carry out another, later, clinical re-assessment (G 8.23). So if the current clinical assessment is that one or all the treatments are not needed immediately, that decision can be re-assessed later. There is no provision in the Regulation stating that the INS/US/not US categorisation assessment is once and for all.
- (14) The longer the timescale, the more likely it may be that the patient will need a wider range of treatments whilst living in England, if the condition or the symptoms are going to worsen over time, because the urgency for treatment may increase. On the other hand, the condition may cure itself or improve and less or no treatment may be needed as time passes.
- (15) There is nothing in the Regulation which impinges on or controls the treatment path, modality or location of the treatment options which the clinician decides to provide. Such decisions are multi-factorial and depend on the disease or condition, the investigations, the patient’s co-morbidities, the hospital’s resources, the staffing and the equipment, medical and college Guidelines and other calls on NHS services which may be temporarily overwhelming (for instance COVID). There are probably also many other matters too numerous to list here.
- (16) The Regulation does not impact upon or alter the standard of care which tort law requires of the NHS and of clinicians.

Applying the Law and Guidance to the facts - determining the issues

Dr. Cross’s decision in December 2019

[103] It is a fact that the decision taken by Dr. Cross on 11th December 2019 on the forward treatment plan was different from the previous treatment plan between August and December 2019. For this patient, with his blood readings (for instance his CCC results were over the threshold of 8 mls/min which is the trigger figure for regular dialysis and other results were likewise), with sufficient residual kidney function, the medical evidence is that the provision of thrice weekly scheduled dialysis was not mandated. The treatment plan she implemented – ad hoc attendance at A & E for

assessment of blood, symptoms and other relevant matters and then dialysis, if needed, provided free of up front charge by the renal department, is not criticised by any medical evidence produced by the Claimant or before me.

- [104] On the evidence there was good reason for the ad hoc plan and advice to attend whenever he felt he needed to at A & E. It facilitated ongoing reassessment of the urgency of his condition as time passed, based on need.
- [105] It was implied by the Claimant that either due to convenience or outcome or for some other reason, regular scheduled dialysis at the Mary Rankin Centre is somehow medically better than dialysis provided in the hospital's renal department. There is no evidence before me that it is. Nor, if it were better, is there any evidence that a "standard plus" level of care was mandated clinically. I consider that the choice was a matter for the internal organisation of the NHS service and the clinician's judgment, taking all matters into account. The NHS can go above and beyond the necessary level of care mandated by any patient's condition and perhaps do so when funds, staff and equipment permit, but that does not entitle any OR or OV patient to demand "standard plus" care. The allocation of NHS resources and the method of delivery of those resources, the choice of treatment pathways or locations or methods, in this claim are matters for the clinicians and the relevant trust, not for judicial review.
- [106] Dr. Cross was required by the Regulations to take into account the Claimant's immigration status and to distinguish between ORs and OVs for valid reasons (charging) and so she did. For instance she was required to try to determine and had to reject providing any non US treatment to the Claimant, without advance payment.
- [107] Whilst Dr. Cross and Dr. Goodlad (para 24 of her witness statement) accept that if the Claimant had been an OR it is "likely" that he would have been provided with twice weekly elective dialysis, the evidence does not show that he definitely would have. For an OR the timescales are lifelong. For an OV the timescale is limited. Status is not an irrelevant factor. The Regulations and legislation make status a relevant factor for clinicians to consider. The issue in this case is how the status factor was deployed.
- [108] What then of the other main criticisms of this decision? On 11 December 2019 Dr. Cross wrote:

"it is my sad duty to inform... that he is not entitled to NHS treatment and that he is, however, entitled to emergency treatment by presenting to an emergency department...."

In her later (2021) witness statement Dr. Cross explained this:

"so I took the clinical decision that the Claimant should not receive regular scheduled dialysis at a designated renal unit without upfront payment because it was not an immediately necessary or urgent service. Rather I advised him to attend any any department... in order to access treatment as needed"

There is a typo in this last paragraph. The second "any" should probably read "A & E". Defence counsel suggested that there was a poor use of written words in this letter (not the witness statement). The letter was dictated on 11 December and sent out on 19 December 2019 without the consultant reviewing and signing it.

- [109] I rule that in law the Claimant was entitled to be considered for any NHS service which was properly categorised as a US in the relevant timeframe without the need for payment in advance, so long as that service provided a reasonable standard of care. If Dr. Cross was saying in the letter that the Claimant was not entitled to NHS treatment even if it was INS or US then she was wrong. Her 2021 explanation of the thinking behind her letter is noteworthy. On that explanation she was correct in law (depending on the timescale). Dr. Cross was right to say that the Claimant was not entitled to dialysis (without up front payment) if it was not INS or US. As I have said above, the decision on which of the various available treatment plans was to be provided was a matter of clinical judgment and the two options under consideration in this claim were, on the evidence before, me both proper options.
- [110] I am required to ask, was option B actually only chosen due to the “apparent” mistake of law I have identified in the letter about status entitlement? I consider that the words in the letter are to be read in the context of what happened in clinic on 11 December 2019 and what was going to happen on the ground and did happen. The proof was in the pudding. Dr. Cross told the Claimant on 11 December 2019 that he would be provided with dialysis if any future A & E assessment of his condition and symptoms, when he visited, disclosed that dialysis was needed and that would be provided in the hospital, presumably as an outpatient, without upfront charging. I note that dialysis was not given on two visits in December 2019, after clinical assessments were made. But on 8th January 2020 dialysis was given after assessment at A & E, with no up front charging, and that system continued. So the words in the letter sent on 19th December, do not match the verbal advice given before the letter was sent out, or the actions from 11 December 2019 onwards. In so far as the letter stated that the Claimant was not entitled to NHS treatment, save at A & E, the written wording was wrong. But Dr. Cross’ words and the hospital’s actions in providing the necessary US treatment, when assessment showed it was necessary to relieve uraemic symptoms, were right and lawful. Therefore I do not find that the decision made on 11 December 2019 was unlawful on the grounds of misapplication of status entitlement.
- [111] The next complaint was that the decision was taken without any express written statement of the relevant timescale for which the Claimant would be living in England. In my judgment Dr. Cross did not have sufficient information on 11 December 2019 properly to be able to assess the “relevant timescale”. Reg. 3(2) was not satisfied at that time. That lack was not the fault of the Defendant’s OVT (team) or Dr. Cross. They had only found out that the Claimant was possibly OV in late November. I have no evidence about how long it took for the Home Office or the Claimant’s immigration advisers to provide the factual evidence needed for the trust’s OVM (manager) to make any decision as to the relevant timescale and to pass it on to the clinicians. That information appears to have been obtained and provided when Dr. Goodlad made her decision on 31st January 2020, but was not available to Dr. Cross. So I consider that no full categorisation decision was made by Dr. Cross on 11 December because she had not been provided with the relevant timescale information, which can only be provided after reasonable efforts to obtain the information by the trust’s OVT. What Dr. Cross did, whether she expressed it properly in her letter or not, was make an interim clinical decision pending obtaining the relevant timescale information. Reassessment was built into the interim treatment plan and so was envisaged at a later date. For those reasons I find no sufficient ground for holding that the interim treatment plan decision taken by Dr. Cross on 11 December 2019 (despite

the potential error in the letter) was unlawful, took into account matters which should not have been taken into account, was perverse, based on a misconstruction of the law or was irrational.

The decision taken on 31 January 2020 by Dr. Goodlad

- [112] This decision was that the Claimant needed treatment and that the treatment fell into the category US. It was made after the clinician had been provided by the OVT with the relevant timescale fulfilling Reg. 3(2). So a decision on categorisation was made using the relevant timescale, namely: the Claimant was reasonably estimated to be likely to live for 6 months or more in England. There is no suggestion in the claim or evidence before me that the relevant timescale estimation was incorrect or irrational. So, on timescale and the US categorisation, I can find no ground for holding that the categorisation decision was unlawful, took into account matters which should not have been taken into account, was perverse, based on a misconstruction of the law or was irrational.
- [113] On 31 January 2020 Dr. Goodlad set out the treatment plan for the Claimant. It was for the Claimant to attend every Wednesday (or more often if necessary) at A & E for blood tests and examination and any necessary assessment (free of any charge: Reg. 9) and then, if necessary, to be taken to the dialysis department in the hospital for further treatment (free of prior charge but charged in arrears), presumably as an outpatient. The rationale for that treatment pathway was set out, based on the medical factors: kidney function, blood tests, symptoms and the need for regular reassessment at A & E.
- [114] There is no evidence before me challenging the evidence from Dr. Goodlad about that clinical judgment. There is no evidence to suggest that the standard of clinical care to be provided by Dr. Goodlad's plan was insufficient (using the A & E route). Were I to try to make such a finding I would be descending into the substantive merits of the clinical decision on standard of care, which I am not allowed to do. In my judgment the treatment plan was a matter for the clinician's discretion and judgment.
- [115] Did Dr. Goodlad take a policy decision instead of a clinical decision when choosing plan B rather than plan A? I consider that the fact that there were, or may have been, other pathways for treatment is nothing to the point unless the pathway chosen was so disadvantageous to the patient that it was in effect a denial of treatment. So if Dr. Goodlad had recommended treatment in a place so far away (Stornaway for instance) that the Claimant could not have reached there or could not have afforded to travel there, the issue would be different. If the treatment pathway chosen was patently not of a sufficient standard that might be different.
- [116] Asking the question again in a different way: did Dr. Goodlad only choose the weekly A & E pathway because the Claimant was OV? Her evidence is that she did not do so wholly on status grounds. Dr. Goodlad has explained that she had medical grounds for the decision. The assessments she had made on the day, allied with the results recorded in the past, the biochemical results and other examination results, showed that scheduled, 3 weekly dialysis was not mandated. Indeed she advised that dialysis itself can hasten loss of residual function. She has given her clinical reasons for the choice. In addition as I have said above, status is required to be considered by clinicians in the decision making process and she took that into account.

[117] I find no ground for holding that the treatment plan decision chosen by Dr. Goodlad was unlawful, took into account matters which should not have been taken into account, was perverse, based on a misconstruction of the law or was irrational.

[118] So in summary I rule that the first decision in December 2019 was a lawful clinical interim decision which envisaged clinical reassessment and was made before relevant timescale information was available. It provided for potential future dialysis, with no up front payment, but only after A & E assessment of this OV patient. The second decision, in January 2020, was a lawful clinical and categorisation decision for US treatment for an OV, made with the relevant timescale information and was a clinically appropriate option on the evidence before me, albeit different from that which *might* have been given to an OR patient.

Harm

[119] The Claimant asserted in his witness statement that as a result of the change of treatment plan in December 2019 he suffered harm. He claims no damages in his Grounds or remedies. No medical nephrology or psychiatric evidence was served or filed in support of that assertion. From the medical records in October and November 2019, when the Claimant was receiving regular scheduled dialysis, he was complaining of very similar symptoms psychiatrically and physically and asserted he could not even travel to the Home Office to report in. If I am wrong on the decisions made above and I had to decide on harm, which I do not, on the evidence before me no harm has been proven to have been caused by the change of treatment plan on 11 December 2019 or the 31 January 2020 treatment plan.

Academic

[120] In claims where the result sought has been obtained long before the judicial review hearing, so the claim is academic, for the Claimant to prove that the claim is not purely academic, exceptionality is needed to justify why it should still be heard. Various conditions must be satisfied. In *Zoolife*, it was stated that the first condition he must prove is that: ‘a large number of similar cases exist or are anticipated’ or at least other similar cases exist or are anticipated. The second condition is that the decision in the academic case will not be fact-sensitive.

[121] On the evidence by 27 March 2020, at the latest, the claim was academic in relation to treatment, in that the requested treatment (which the Claimant had altered from 3 times pw at the Mary Rankin Centre to 2 times pw in his Reply, dated 25 March 2020) was being provided.

[122] The Claimant and DoW submit that there is a point of general public importance on the basis that clinicians are misunderstanding how to apply the Regulations for OVs.

[123] I take into account the 6-8 case studies produced by DoW during the 6 years since the 2015 Regulations were introduced. I make no findings on the facts of the brief case reports summarised helpfully by DoW. These were not answered or accepted in detail by any of the trusts involved

[124] I also take into account not only the long and detailed main Guidance published and updated from the Department, but also the Operational Framework guidance. Those

public guidance documents set out, with clarity in my judgment, what clinicians and trusts should do in relation to treatment for OVs.

- [125] I also take into account that the provision of free INS and US medical care to OVs is a matter which was being decided in a more fluid form long before 2015. The case *R (A) v Sec of State for Health [2009]* EWCA Civ 225 shows that very clearly. Since that case the Regulations have been drafted, debated and passed by Parliament and the two forms of guidance have been issued.
- [126] If trusts need to train their clinicians on the application of the Regulations and the Guidance that is a matter for them and perhaps for the 2nd intervener to promote and get involved in if funds permit and they so wish.
- [127] I make no criticism of the Defendant hospital or the clinicians in this claim who appear to me to have had the Guidance well in mind.
- [128] I do not consider that there is a point of public importance in this claim which needs clarification by this court. In this field, as in so many fields of medicine, clinicians have to make judgment calls on difficult issues. Funding always makes such decisions even more tricky. The last thing they need is courts, through judicial review, seeking to substitute judges' views about clinical matters concerning the allocation of NHS resources, on patients' clinical needs for treatment and on the correct method of delivering treatment or the correct location or frequency for treatment. That is the province of tort law should breach occur and damage be caused by such breach.
- [129] This claim was fact specific. I have decided it on the evidence and the legislation and by applying the guidance.
- [130] I do not consider that either of the two conditions are satisfied on the evidence before me for the claim to escape the label "academic".
- [131] In reaching this decision I take into account the rulings in *R (Heathrow Hub) v Sec of State for Transport [2020]* EWCA Civ 213 @ para 208 as well as *R (Zoolife) v Secretary of State [2007]* EWHC 2995, set out above.
- [132] So on the 4th issue: whether the judicial review claim is now and has been for a long time academic in the light of (1) the provision, starting on the 27th of March 2020, of scheduled, twice weekly dialysis at the Mary Rankin Centre; and (2) the provision in October 2021 of the grant of leave to the Claimant by the Home Office to stay in England for 30 months, I rule that the claim is academic and has been since 27 March 2020 or before if a communicated decision to start scheduled dialysis was received before that date by the Claimant, his agents or GP.

The Conclusions

- [133] **Judgment** The claim is dismissed. The relief is not granted. The anonymity order will be continued to cover reporting on this judgment and on any appeal and the court files, electronic and papers shall be marked in such a way as to prevent the identity of the Claimant being disclosed to any person who seeks to obtain a copy of a document from the court file. I shall hear submissions on how the order should be drafted.

[134] **Costs** I will hear submissions on costs at the adjourned hearing. I am currently minded to order that the Claimant shall pay the Defendant's costs to be assessed on the standard basis if not agreed. Further that there shall be no costs in relation to the interventions by the first and second interveners.

Ritchie J

End