Neutral Citation Number: [2023] EWHC 980 (Admin)

Case No: CO/1016/2022

**IN THE HIGH COURT OF JUSTICE**
**KING'S BENCH DIVISION**
**ADMINISTRATIVE COURT**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28/04/2023

**Before**:

**MR JUSTICE CHAMBERLAIN**

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**Between:**

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| **F** | **Claimant** |
| **– and –** | |
| **SURREY COUNTY COUNCIL** | **Defendant** |

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**Grainne Mellon and Isaac Ricca-Richardson** (instructed by **Watkins Solicitors**) for the **Claimant**
**Katherine Eddy** (instructed by **Surrey County Council**) for the **Defendant**

Hearing dates: 9 February 2023

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# Approved Judgment

This judgment was handed down remotely at 10.30am on [date] by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE CHAMBERLAIN

**Mr Justice Chamberlain:**

## Introduction

1 The claimant is a recovering alcoholic. In April 2021, his mother was very concerned about him and telephoned i-access, a drug and alcohol service provided by Surrey and Borders Partnership NHS Foundation Trust ("SaBP") on behalf of Surrey County Council ("the Council"). She says that they refused to provide treatment unless he first undertook an alcohol reduction programme, but it was not safe for him to undertake that programme. She arranged for him to be admitted as an in-patient to a private facility, to receive medically assisted alcohol detoxification ("detox") treatment. The cost of the treatment was £19,650. It was paid with the assistance of a loan from the claimant's father. After 15 days, the treatment was successful and the claimant has been sober ever since. In November 2021, his mother asked the Council ("the Council") to reimburse the cost of the treatment. On 23 December 2021, the Council refused. By this claim the claimant challenges what he describes as the Council's "blanket policy" not to offer residential detox to patients who have not undertaken an alcohol reduction programme and the refusal to reimburse.

2 The original grounds of challenge were: that the Council (1) operates an inflexible and/or irrational unpublished policy; (2) failed to publish the policy; (3) acted procedurally unfairly; and (4) breached the claimant's rights under Article 14 ECHR read with Article 8. The relief claimed was a quashing order of the refusal to reimburse of 23 December 2021 and damages for breach of Convention rights.

3 Permission was refused on the papers by Bennathan J on 21 July 2022. Ground 3 was abandoned before the oral permission hearing on 3 November 2022. At that hearing, I granted permission to apply for permission to apply for judicial review on grounds 1 and 4, but refused permission on ground 2. The Council filed its Detailed Grounds of Defence and evidence on 8 December 2023. One of the documents disclosed was SaBP's Community Detox Team Operational Policy dated June 2018 ("the Operational Policy"). On 23 January 2023, the claimant applied to amend the Statement of Facts and Grounds to challenge the Operational Policy (ground 1.1), its application in this case (ground 1.2) and the failure to disclose it (ground 1.3). Amended relief was also claimed, in particular, a declaration that the Operational Policy is unlawful, though this was not pursued at the hearing. The Council opposes the application to amend, saying that it has been made too late and that the inclusion of ground 1.3 is an attempt to revive the original ground 2, in respect of which I refused permission to apply for judicial review, and therefore an abuse of the process of the court.

4 Although there is some force in the submission that the application to amend should have been made sooner than 23 January 2021, it has not been necessary for me to consider in detail the procedural arguments for and against amendment, because I have concluded that, even if the application were granted, the new points would not assist the claimant. That being so, there is no point in allowing the amendment and I therefore refuse the application.

## The facts

*The lead-up to the claimant's admission to the private facility*

5 The claimant started to become dependent on alcohol while studying at university. His alcoholism worsened during the lockdowns imposed for the Covid-19 pandemic. By Christmas 2020, he was drinking approximately 40 units per day. His weekly intake was 20 times above the recommended safe amount. He realised that this level of drinking was unsustainable and resolved to stop. He planned to reduce his intake gradually, but was unable to do so because of anxiety and mental instability. From the second week of January 2021, he began vomiting because of the quantity of alcohol he was drinking. This meant that he was ingesting less alcohol. On the afternoon of 16 January 2021, he had an alcohol withdrawal seizure and was taken by ambulance to the Royal Surrey County Hospital ("RSCH"), where he was prescribed Librium, a medicine used for detox.

6 On 17 January 2021, two doctors came to see the claimant. They told him that the RSCH was not an alcohol rehabilitation facility. He would therefore be discharged on the following day, after receiving advice from an alcohol liaison nurse ("ALN"). The ALN was Sian Davies. On 18 January 2021, she visited the claimant twice. The clinical notes record the nurse saying that the claimant was "unlikely to be eligible for community detox services as no prior engagement to do abstinence preparation" and that because he was physically dependent on alcohol he should aim for "reduction of alcohol use rather than abrupt cessation". This accords with the claimant's recollection that he was told that he would have to continue to drink alcohol to avoid another seizure. The nurse recorded that she had made a referral to "i-access".

7 i-access attempted to contact the claimant by letter and text message on 19 January 2021, and by telephone on 4 February 2021. The letter offered "a Telephone Assessment in the first instance" and gave a number to call to arrange such an assessment. It continued:

> "It is important to note that if we do not hear from you by **Tuesday 26th January 2021**, we will assume that you do not wish to access support from our service at this time and close your referral" (emphasis added).

8 The claimant did not respond to the letter or text. He did take the telephone call, but ended it saying that he was expecting a call from his university tutor. On 17 February 2021, i-access sent the claimant a letter, copied to his GP, saying that they were closing his file, but he should not hesitate to contact them if he required support in the future.

9 The claimant's mother describes in her witness statement what happened when the claimant returned home from hospital in January 2021. He began withdrawing within hours. He drank to alleviate his symptoms and spent most of each day in bed stressing about when his next drink was due. The need to avoid another seizure took over his life. He could not entertain the idea of reducing his drinking. Any suggestion of it led him to become uncontrollably stressed.

10 By April 2021, the claimant was in crisis. By 15 April 2021, he had stopped eating and begun vomiting again. His mother's evidence is that she contacted the (private) addiction treatment providers to see if he could be detoxed in the community, as this was significantly cheaper than in-patient detox treatment. They all advised that he did not qualify for community detox because he was at high risk due to his recent seizure, recent

partial detox and level of alcohol usage. On 19 April 2021, with the claimant's permission, his mother called his university GP, who said that it was local authorities' responsibility to commission and provide drug and alcohol treatment.

11 The claimant's mother's evidence is that she then called i-access three times, on 19, 20 and 21 April 2021. On each occasion she spoke to a different member of staff. All three staff members responded that the service did not provide detox as a first treatment. It was mandatory to engage in an alcohol reduction programme first. The only assessment that could be offered was an assessment to see whether the claimant was suitable for an alcohol reduction programme. If so, and if he began such a programme, they would conduct a review at the six-week point and might then assess whether he was suitable for detox.

12 The i-access patient records do not include any reference to the calls on 19 or 20 April 2021. A call at 9.02 am on 21 April 2021 is recorded and a secure electronic message was sent to Elizabeth Findlay, a specialist substance abuse nurse. She called the claimant's mother back the same morning. The record of that call shows that the claimant's mother said that the claimant was "having a private detox at the [private facility] this friday 23rd april". The claimant's mother says that this is an incomplete record of what was said. She says it would have made no sense to call i-access simply to tell them that the claimant was going to have detox privately. She says that there was a conversation about whether i-access could help and it was only when it became clear that they could not that she said that the private facility had offered a bed from 25 April 2021 and they would have to confirm that they wanted to take that bed up by 23 April 2021.

13 It is common ground that there was a further telephone call between the claimant's mother and Martyn Munro, the Council's Senior Public Health Lead, on 21 April 2021. The claimant's mother's evidence is that Mr Munro "reinforced the position put forward by i-access that the service can only provide a reduction programme for the Claimant as he had not done one before", but that after she pressed him he said he would speak to the service and come back to her later that day. He did not, however, get back to her, so they accepted the bed at the private facility.

14 Mr Munro's recollection was that the claimant's mother had told him that i-access had said they could not assess the claimant for residential detox. This did not accord with his understanding of the process, so he offered to check the position with the i-access leadership. He left a voicemail for Katie Matthews, Associate Director of Substance Misuse Services at i-access detailing what the claimant's mother had said (but on a no-names basis). Ms Matthews replied by email the following morning (22 April 2021) in the following terms:

> "He was referred to us in February but terminated call when we tried to arrange appointment and then did respond to requests to contact so discharged.
>
> His mother rang on the 21st April and spoke with Liz Findlay, mother reported he was drinking and vomiting, Liz gave usual advice and mother stated he was being admitted to [the private facility] this Friday for a detox so he has not been opened us as there is no referral.

Obviously he can self refer to i-access but it sounds like they have gone down the detox now private route."

15 Mr Munro had a further conversation that day with Ms Matthews. She explained to him that i-access operated a person-centred assessment approach. For most people, the treatment programme would involve engagement and stabilisation via a group and one-to-one but this would be a decision for the clinical practitioner in light of the assessment.

16 Meanwhile, the claimant had been assessed by the private facility on 21 April 2021 by telephone from his bed. He was admitted on 25 April 2021. He underwent medically assisted detox treatment, which took longer than usual, and he was discharged on 22 May 2021. As I mentioned at the outset, and to the claimant's great credit, he has remained sober ever since.

17 There was a call between the claimant's mother and Mr Munro on 27 April 2021 in which she told him that the claimant had been admitted to the private facility.

*Correspondence about reimbursement*

18 There was no further contact between the claimant's mother and Mr Munro until 15 November 2021. On that day, she emailed Mr Munro seeking a refund of the money spent on the claimant's detox treatment at the private facility. That request was refused by email on 23 December 2021. Mr Munro said:

> "assessment appointments were offered by both telephone and then in person as per the referral process. These were both refused by your son and you on his behalf. Signposting to primary care and urgent and emergency care were also made regarding the health needs your son was displaying at that time. In the circumstances, we do not agree that your son was refused access to treatment and we are not responsible for any costs payable to the private substance misuse treatment provider for your son's treatment."

## The defendant's evidence

19 The defendant has filed witness statements from Martyn Munro and Fiona Robinson, a consultant employed by SaBP who is responsible for the i-access team.

20 Mr Munro explains that the Council commissions i-access, an integrated substance misuse treatment service, from SaBP. A revised model for detox was established by i-access in 2018. There are different types of detox available: home (which involves regular visits from a nurse), ambulatory (which involves attendance at a clinic every weekday morning) and in-patient (at a location outside Surrey). Treatment through i-access begins with an initial assessment undertaken by clinical practitioners. The first stage is usually an alcohol reduction programme called the Abstinence Preparation Group. However, if the clinical practitioners who carry out the initial assessment consider that it would be appropriate to refer an individual directly for detox (with in the community or in an in-patient facility), they can do so.

21 Mr Munro says that, in considering the claimant's mother's request for reimbursement, he took a number of factors into account, in particular that i-access had offered the claimant an assessment on a number of occasions and that assessments had been refused

on the basis that they would not be assured to deliver the outcome of residential detox. Mr Munro knew that the claimant's mother was saying she had been told that an assessment could never result in treatment. He knew that there was no such rule and that i-access had reviewed internally the information provided to the claimant's mother on 21 April and that the member of staff had accurately described what was available.

22 Dr Robinson explains at paras 17-22 of her witness statement that a comprehensive assessment comprising two stages, with the first by telephone and the second usually in person, is a necessary prerequisite to developing a treatment plan. At paras 23-32, she explains the "standard alcohol treatment pathway", which consists of three stages: preparation, detoxification and relapse prevention. At para. 34 she says this:

> "I understand that the Claimant is contending that there is a mandatory rule that all individuals referred to i-access need to undergo an alcohol reduction programme before we will consider detoxification. This is not true. Every individual has different circumstances and needs. There is no 'one size fits all' in terms of treatment of addiction. If an individual is unable to tolerate alcohol reduction in the community or is unable to engage in the process of pre-habilitation then it may be appropriate to consider proceeding directly to detoxification. This flexibility is reflected in the Operational Policy."

23 The Operational Policy provides materially as follows:

> "Alcohol detoxification is only needed for someone who has developed alcohol dependence syndrome with physiological dependence. There would normally be symptoms of alcohol withdrawal e.g. sweating, sleep disturbance, retching, anxiety and tremor as their blood alcohol level drops. The severity of dependence and withdrawal is measured through a combination of clinical assessment and judgement and through the administration of the Severity of Alcohol Dependence Questionnaire (SADQ (Appendix 1).
>
> The following criteria will apply for consideration for assessment by the Community Detox Team:
>
> a. 'In active treatment with i-access East, North or South West'
>
> b. 'A desire to be abstinent from alcohol'
>
> c. 'SADQ score equal to or greater than 16'
>
> d. 'Completion of 6 sessions of Abstinence Preparation Group (APG)'
>
> In exceptional circumstances, the multidisciplinary team may exempt an individual from completing the APG pathway before referral to the Community Detox Team.
>
> Additionally, people who have had detoxification commenced as an emergency in other health settings and who would like to continue with their treatment programme, may complete the process on an ambulatory basis by

> attending the community detoxification centres if assessed as appropriate and safe by Community Detox Team staff."

24 Dr Robinson continues as follows at para. 35:

> "I can attest to the fact that we have referred a number of individuals for inpatient detoxification who have been unable to engage in a reduction plan in the community. This can be for a variety of reasons including impaired cognition, severe anxiety about reduction, or mental health problems that have become apparent to us during the assessment process…."

25 At para. 36, she explains that there are limits to how "direct" proceedings to detox can be, because there is a national shortage of in-patient detox beds. At para. 54, Ms Robinson say that it is common for callers to request emergency detox treatment, but i-access does not offer such a service. She continues:

> "In these cases, they will be told there is no access to emergency detoxification and that people will be expected to engage with the service (i.e. participate in the assessment process) to allow formulation of an appropriate care plan to meet their needs. It may be that this has been mis-interpreted by [the claimant's mother] to mean we do not offer detoxification unless a person engages with a reduction programme"

26 At para. 56, Ms Robinson says that she has spoken to Ms Findlay, the nurse who spoke to the claimant's mother on 21 April 2021. Ms Findlay has no recollection of the conversation but "is adamant that she would not have said that we cannot offer any treatment to someone who could not reduce alcohol use in the community. This has never been the situation."

## Ground 1

27 The claimant's ground 1 (as amended) is that, before his admission to the private facility, the defendant applied an inflexible and/or irrational unpublished policy which does not require or enable each request for treatment to be considered on its merits (ground 1.1); as applied in this case, did not involve a genuine consideration of the individual merits (ground 1.2); and was unlawful because it was not disclosed (ground 1.3). This, the claimant says, is relevant to the reimbursement decision of 23 December 2021 because, if the refusal to provide treatment on or before 21 April 2021 was unlawful, that was a factor that had to be taken into account in deciding whether to reimburse. It was not taken into account, so the decision should be quashed and the defendant will have to re-take it, on the basis that the refusal to provide detox treatment prior to 21 April 2021 was unlawful.

*Submissions for the claimant*

28 Graínne Mellon for the claimant submits that the Operational Policy, on its true construction, does not "genuinely recognise" the possibility of residential detox without undertaking an alcohol reduction programme. On a plain reading of the policy, a patient can, exceptionally, be referred for in-patient detox if he has not "completed" the APG, but not if he has not started it; he must be in "active treatment" with i-access.

29 As to the way in which the Operational Policy is – and in this case was – applied in practice, Ms Mellon relies on seven points:

(a) In a Frequently Asked Questions document published after a consultation in 2018, the final sentence of the answer to question 10 of that document was in these terms:

> "All people with a history of alcohol dependence will need to have engaged in the abstinence preparation group programme first before being considered for detoxification."

(b) In an email sent in April 2022 (i.e. after the claim had been filed) by Anthony Gartland, manager of the Alcohol Liaison Service at RSCH, to the claimant's mother, Mr Gartland confirmed her summary of the conversation, which includes this:

> "The ALS has not had any success to date in requests for patients to continue their detox upon discharge through i-access, where the person has not already carried out alcohol reduction work with them. This is because i-access strictly applies the rule i.e. it is a mandatory."

(c) In their response to the letter before claim, the Council confirmed that the number of people over the last three years who had undertaken a residential detox programme funded by the Council without having first engaged in a programme to reduce alcohol use was zero.

(d) Mr Munro's evidence about his contact with i-access is inconsistent. First, he said that there was no record of any discussions. Subsequently, however, the email to Ms Matthews was disclosed.

(e) The claimant's mother's evidence is, by contrast, better. The relevant events were seared on to her memory.

(f) There is no direct evidence from any of the i-acess staff who actually spoke to the claimant's mother, only indirect evidence from Dr Robinson based on her conversation with Ms Findlay.

(g) The Operational Policy does not assist. It had not been made public and was not known to the claimant or his mother at the time when the enquiries were made.

30 Ms Mellon submits further that the application of an unpublished Operational Policy was itself unlawful: *R (Lumba) v Secretary of State for the Home Department* [2012] AC 245.

31 If the Council unlawfully failed to entertain the possibility that he might be suitable for residential detox without first undertaking an alcohol reduction programme, the Council had a discretion to put right its past unlawfulness: *GE (Eritrea) v Secretary of State for the Home Department* [2014] EWCA Civ 1490, [54]-[55]; *SL (Vietnam) v Secretary of State for the Home Department* [2010] EWCA Civ 225, [33] and [41]. The reimbursement decision was vitiated by Mr Munro's failure to recognise that the claimant had been treated unlawfully on or before 21 April 2021, when it was made clear that undertaking an alcohol reduction programme was a *sine qua non* of eligibility for residential detox.

*Submissions for the defendant*

32 Katherine Eddy for the defendant submitted that the Council does not have an inflexible, mandatory rule that it will only fund residential detox if a person has first completed an alcohol reduction programme. There was no application to cross-examine the defendant's witnesses. In judicial review, in the absence of cross-examination, the defendant's evidence is shown to be correct unless documents or other objective evidence shows it is to be incorrect. There are two disputes of fact: first, as to whether the defendant has an inflexible policy as alleged; second, as to what was said to the claimant's mother.

33 The first should be resolved in the defendant's favour, given Dr Robinson's clear evidence and the terms of the Operational Policy. As to what happened in this case, this dispute too should be resolved in the defendant's favour. The claimant's mother's witness statement was made almost a year after the telephone calls took place. She has not disclosed any contemporaneous notes. I-access has no record of the first two calls she relies on (on 19 and 20 April 2021). None of the contemporaneous records corroborate her account that she was told i-access "can only offer an assessment to see if the Claimant is eligible for support with alcohol reduction", nor that i-access would be unable to help if the assessment showed that he was unsuitable for alcohol reduction work. The accounts given of interactions with i-access staff are not accurate descriptions of the way that i-access operates, nor of the purpose of i-access assessments.

34 In any event, the claimant's challenge also fails on the law. Even if unlawful past conduct may in some circumstances constitute a material consideration in the exercise of a later discretion, it does not follow that the Council was bound to have regard to its own past unlawfulness on the facts of this case, especially where the past unlawfulness had not been established at the time of the challenged decision. At most, the obligation on Mr Munro was to consider whether there had been unlawful conduct in the past, which he did.

*The real target of the claim*

35 The Claim form identifies the decision challenged in this case as "the Defendant's reliance on an unpublished, blanket policy to refuse to assess for and/or provide residential detox as a first treatment for alcohol addiction, and the Defendant's decision of 23 December 2021 to refuse to recompense the Claimant for consequential loss". The date of this "decision" is said to be 23 December 2021. What the claimant is really seeking to achieve is the quashing of the refusal to reimburse and the reconsideration of the request for reimbursement.

36 The amended relief sought was framed more widely than that and included relief declaring the Operational Policy, or its application to the claimant, unlawful. But the application for a declaration was not pursued at the hearing and, in any event, on the claimant's case, the latest date on which the "blanket policy" was applied to him was 21 April 2021. Any challenge to that decision would be out of time. In any event, the defendant has produced evidence in the form of Dr Robinson's witness statement, which exhibits the Operational Policy and says that a patient can in principle be assessed as suitable for residential detox without first undertaking an alcohol reduction programme. The first question is therefore whether the Operational Policy does indeed permit residential detox without first undertaking an alcohol reduction programme.

*The correct construction of the Operational Policy*

37 Before embarking on a detailed linguistic analysis of the Operational Policy, it is important to stand back and remember that this was a policy document drafted by and for non-lawyers setting out the approach to delivery of a clinical service by clinicians. There is a real danger in reading every policy document as if it were a statute. Where, as here, the issue concerns the circumstances in which a particular treatment option may be provided, it is permissible – and indeed sensible – to read the document in the light of the defendant's evidence about the actual approach adopted by clinicians.

38 That evidence is provided in this case by Dr Robinson. She is a consultant medical practitioner who has worked with SaBP's drug and alcohol services for over 20 years. She has extensive experience of the assessment and management of people with alcohol dependence. On the initial question of what the policy is, there is no reason to doubt any part of her evidence. That evidence establishes the centrality of the clinical assessment as the starting point for the development of a treatment plan, the strong preference for adherence to the treatment pathway, but also the ability to depart from that pathway if clinically required in the particular circumstances of an individual case.

39 Against that background, the requirement that those referred for residential detox must be "in active treatment with i-access" is best read as requiring them to have a treatment plan following assessment. No doubt, in the vast majority of cases, the plan will involve an alcohol reduction programme before detox commences. However, the Operational Policy also provides:

> "In exceptional circumstances, the multidisciplinary team may exempt an individual from completing the APG pathway before referral to the Community Detox Team."

40 In my judgment, Ms Mellon's suggested reading of this paragraph places too much weight on the word "completing". In context, the Operational Policy is saying simply that, in exceptional cases, clinicians may conclude that the APG pathway is inappropriate to the circumstances of a particular patient.

41 I therefore read the Operational Policy as saying that, in exceptional cases, a patient might be referred for detox without having first undertaken any part of an alcohol reduction programme, if after an assessment such a programme is regarded as clinically contra-indicated. The immediately following paragraph, which deals with the position of those who have started detox in emergency or other health settings, is consistent with this.

*The general application of the Operational Policy in practice*

42 Despite the provision for exceptional cases, there is no doubt that there is a strong steer, reflected in the Operational Policy and in Dr Robinson's evidence, that in the vast majority of cases a patient should undertake an alcohol reduction programme before being referred for detox. That strong steer appears to have been stated in overly absolute terms in the FAQ document relied upon by Ms Mellon. I accept the evidence in Mr Munro's third witness statement that this document was intended as a summary of the main themes and responses to a consultation about changes to the service and was not a document prepared by or for clinicians.

43 The idea that there was a mandatory rule requiring participation in an alcohol reduction programme before detox was also held by Mr Gartland, but he is not an employee of the Council or of SaBP. It is not surprising that he should have thought this if, as stated in the Council's response to the letter before action, no patients had been referred directly to residential detox in three years preceding the date of that letter.

44 None of this, however, supplies a reason to doubt the clear and specific evidence given by Dr Robinson in para. 35 of her witness statement (see [21] above) that "we have referred a number of individuals for inpatient detoxification who have been unable to engage in a reduction plan in the community". Specifics are not given, but one would not expect them to be, given the need to maintain patient confidentiality. I accept what Dr Robinson says as correct.

45 Accordingly, I conclude that the Operational Policy, as applied in practice, did allow i-access exceptionally to refer patients for detox treatment without having engaged in an alcohol reduction programme.

*The proper approach to the factual dispute about what the claimant's mother was told*

46 In general, a court hearing a judicial review claim does not resolve disputes about primary fact. This is because, in general, the issues for the court to determine do not turn on the resolution of such disputes. Typically, the court focuses on the procedure adopted before the decision was made; whether the decision-maker was entitled to conclude the information before him was sufficient; and whether the decision-maker identified and answered what in law were the right questions, approached and structured his task in a logically acceptable way, gave adequate and intelligible reasons and reached a decision that was open to him on the evidence. In most cases, a claim alleging a flaw of this kind will not depend on the resolution of any dispute about primary fact. When a decision is challenged on the basis of material error of fact, the claimant is required to show that the fact is "uncontentious and objectively verifiable" rather than one that the court has to determine for itself: see e.g. *R (Law Society) v Lord Chancellor* [2018] EWHC 2094 (Admin), [2019] 1 WLR 1649, [98].

47 When a claimant invites the court to resolve a dispute of fact, the invitation is sometimes an indicator of his inability to identify a proper public law ground on which the challenged decision can be impugned. There are, however, situations in which a genuine public law ground of challenge requires resolution of a dispute about a primary fact. In that situation, it is often claimed that there is a general principle that the defendant's written evidence is to be preferred, unless exceptionally the court permits cross-examination or the evidence "cannot be correct": see e.g. *R (Safeer) v Secretary of State for the Home Department* [2018] EWCA Civ 2518, [16]-[19] (Nicola Davies LJ); *R (Singh) v Secretary of State for the Home Department* [2018] EWCA Civ 2861, [16] (Underhill LJ). The scope of the "cannot be correct" exception was explained by Stanley Burnton J in *S v Airedale NHS Trust* [2002] EWHC 1780 (Admin), at [18]: "There may be an exception where there is undisputed objective evidence inconsistent with that of the witness that cannot sensibly be explained away (in other words, the witness's testimony is manifestly wrong)…"

48 There are, however, other equally authoritative statements which put the principle more neutrally and do not refer to any presumption in favour of the defendant. In *R (Talpada)*

*v Secretary of State for the Home Department* [2018] EWCA Civ 841, Hallett LJ said this at [2]:

> "If there is a dispute of fact, and it is relevant to the legal issues which arise in a claim for judicial review, the court usually proceeds on written evidence. Since the burden of proof is usually on the person who asserts a fact to be true, if that burden is not discharged, the court will proceed on the basis that the fact has not been proved. It would be an exceptional case in which oral evidence was needed by the Administrative Court – or the Upper Tribunal when exercising its judicial review jurisdiction."

49 There are many instances in which the courts have resolved questions of fact on the basis of written evidence without cross-examination, sometimes against defendants: see, for example, the cases referred to by Sir Michael Fordham in his *Judicial Review Handbook* (7th ed., 2020), at para. 17.3.12.

50 In my judgment, the correct approach is as follows:

(a) If invited to resolve a dispute of primary fact, the court should consider carefully whether any pleaded ground of challenge really requires resolution of the dispute. In most cases, the answer will be that the resolution of the dispute was for the decision-maker, not the court: the court's supervisory function does not require it to step into the shoes of the decision-maker and therefore does not require it to resolve the issue for itself.

(b) Where the resolution of a dispute of primary fact is necessary, the court usually proceeds on written evidence: see e.g. *Talpada*, [2]. The court will generally do so if – as here – no application to cross-examine has been made before the start of the substantive hearing.

(c) There is no absolute rule that the court must accept in full every part of the statement of a witness who has not been cross-examined, whether the statement is adduced for the claimant or the defendant. The court can reject evidence in a witness statement if it "cannot be correct" (*Safeer*, [16]-[19] and *Singh,* [16]). That might be so if it is contradicted by "undisputed objective evidence… that cannot sensibly be explained away": *S v Airedale*, [18]. But there are also examples of courts rejecting evidence given in witness statements as, on balance, inconsistent with other written evidence: see e.g. *Talpada*, [48].

(d) In some cases, the court may be unable to resolve a conflict of written evidence on a question of primary fact. In that situation, "the court will proceed on the basis that the fact has not been proved": *Talpada*, [2]. This will be to the disadvantage of whichever party asserts the fact. That will generally be the claimant, because in judicial review the claimant generally bears the burden of proving all facts necessary to show that the decision challenged is unlawful. Thus, the principle that the defendant's evidence is to be preferred, save where it "cannot be correct", arises because of the difficulty of satisfying the burden of proof where there is a conflict in written evidence, not because evidence adduced on behalf of a defendant is inherently more likely to be true than that adduced on behalf of a claimant.

*Does the court need to decide what was said to the claimant's mother on the telephone?*

51 If, as the claimant says, i-access refused to assess him other than with a view to his participation in an alcohol reduction programme, that refusal must have been communicated on or before 21 April 2021. As I have noted, the Claim Form does not challenge any such refusal. It challenges a decision taken on 23 December 2021. That was a decision to refuse reimbursement. In taking the decision, Mr Munro had to decide a question of primary fact: was the claimant refused access to treatment because his clinical presentation made him unsuitable for an alcohol reduction programme?

52 The issue for the court is whether, in deciding that question, Mr Munro made any justiciable public law error. In my view, he did not. He knew something of the background to the case because he himself had spoken to the claimant's mother on 21 April 2021. He made enquiries of Ms Matthews (see paras 11 and 12 above), who explained the approach that i-access took and (in brief) what had happened in this case in an email on 22 April 2021 and in a telephone call later that day.

53 Mr Munro's reasons were, in essence, that "assessment appointments" had been offered, and that these had been "refused by your son and you on his behalf". This was true. An offer of an assessment was made by letter and text message on 19 January 2021 and, after the deadline for responding had passed, by phone call on 4 February 2021. It is common ground that these offers were made and not taken up. As to what was said in April, Mr Munro said simply that an offer of an assessment had been refused by the claimant's mother on his behalf. Her evidence was that any assessment would be of the claimant's suitability to undertake an alcohol reduction programme. On her case, she refused this on the claimant's behalf because she believed that he was not suitable for such a programme. But the fact remains that an assessment was offered and refused.

54 Mr Munro's decision did not involve any finding of fact about what was or was not said to the claimant's mother. That being so, the only basis on which it might be said that the decision was unlawful is that he should have proceeded on the basis that she had been told that detox treatment was not available without first undertaking an alcohol reduction programme. But, whether or not she had been told that, the question for the court is whether he erred in declining to proceed on that basis. In my view, he did not. He had made the necessary enquiries, which revealed that an assessment had been offered and refused on a number of occasions. He had informed himself of the general approach taken by i-access, which, as Ms Matthews put it, was to adopt a "person-centred assessment approach". He took the view that, in those circumstances, there was no warrant for reimbursement. There was in my judgment no obligation on him to go further.

55 The point can be tested in this way. From the perspective of Mr Munro, acting as decision-maker, it is impossible to know what would have happened if the offer of an assessment had been accepted. It may be that the claimant would have been one of the exceptional patients accepted for residential detox without first undertaking an alcohol reduction programme. Alternatively, the clinical assessor might have decided that, contrary to the claimant's mother's view, he could safely begin to reduce his consumption before being admitted on to such a programme. The claimant's mother decided that she did not want to wait and see. In those circumstances, I can see no justiciable public law error in refusing the request for reimbursement, for the reasons given by Mr Munro.

*What was the claimant's mother told?*

56 If, contrary to my view, it were necessary to resolve the factual dispute about what the claimant's mother was told, I would find as follows:

(a) I accept that the claimant's mother's witness statement contains her honest recollection of the conversations she had. However, as she herself makes clear, she was "frantic with worry" in the period immediately before the claimant's admission to the private facility in April 2021. This is understandable, given the parlous state of the claimant's health. However, her anxiety may have affected the reliability of her recollection.

(b) The claimant's mother did not take any contemporaneous note of the relevant conversations. Again, this is understandable, but the fact remains that the first time her recollection was put into writing was when she requested reimbursement, nearly 5 months later.

(c) i-access appears to operate a good record-keeping system, but there is no record of any telephone call on 19 and 20 April. However, i-access do not always record calls. There were telephone records from the claimant's mother showing that a call was made. However, it is not possible, in the light of the points in (a) and (b) above, to make a positive finding about what was said in those calls.

(d) It is common ground that there was a conversation between the claimant's mother and Ms Findlay on 21 April. It is likely that, during that conversation, Ms Findlay explained that the standard treatment pathway involves undertaking an alcohol reduction programme before detox. She may well have said that deviation from the standard treatment pathway was unusual. The real question is whether Ms Findlay went further and said that, if the claimant were unsuitable for an alcohol reduction programme, there was no treatment that could be offered.

(e) Dr Robinson explains that Ms Findlay is an experienced nurse who has worked for over 20 years and she is "adamant that she would not have said that we cannot offer any treatment to someone who could not reduce alcohol use in the community". Although this is not direct evidence from Ms Findlay, it is entitled to considerable weight. In the light of the points in (a) and (b), I am unable to make a positive finding that Ms Findlay said what she is adamant she would not have said.

57 Even if it were necessary to consider as a matter of fact what the claimant's mother was told, when he refused the claimant's mother's application for reimbursement, Mr Munro did not act unlawfully by failing to take into account the unlawful refusal of treatment, because I am unable to make a positive finding that there was such a refusal.

*Conclusion as to ground 1.1 and 1.2*

58 For the reasons set out above, amended ground 1.1 and 1.2 fail.

*The circumstances in which a decision-maker has an obligation to consider past unlawfulness*

59 The conclusions I have reached mean that it is not necessary to consider the circumstances in which Mr Munro had a duty, when taking the reimbursement decision, to consider any prior unlawful conduct on the part of the Council. That would have

required consideration of whether the decisions of the Court of Appeal in *GE (Eritrea)* and *SL (Vietnam)* establish a principle that a decision-maker exercising a discretion must have regard to any undetermined allegation of prior unlawful conduct; and if so whether that principle applies generally in public law (i.e. outside the immigration context). These are potentially important questions, which should be determined in a case where they matter.

*The alleged obligation to publish the Operational Policy*

60 Ground 1.3 depends on three propositions. First, in general, if a public authority has a policy relevant to the exercise of its discretion, it has an obligation to publish that policy. Second, because the council breached its obligation to publish the Operational Policy, he was not aware that it provided for access to detox without undertaking an alcohol reduction programme in exceptional circumstances and, had he been so aware, "sought to engage with" the Council to rely on this. Third, this unlawfulness was relevant to the legality of the reimbursement decision and should result in the quashing of that decision (see para. 44 of the proposed Amended Statement of Facts and Grounds).

61 It may be observed that the second of these propositions is flatly contrary to the case advanced under ground 1.1, which was that the Operational Policy, on its true construction, did <u>not</u> allow those who had not at least begun an alcohol reduction programme to access detox treatment. I have, of course, rejected that construction, but I do not see how the claimant can properly argue that he has been prejudiced by the failure to disclose a policy which – on his own case – did not assist him.

62 The third proposition is also not made out, for this and another reason. Given that I cannot make a positive finding that the claimant's mother was told anything materially different from what was in the Operational Policy, the failure to publish it cannot have been material to the reimbursement decision.

63 This means that, even if I were to accept the first proposition and conclude that there is a general obligation to publish every policy relevant to the exercise of a discretion, it would not assist the claimant in challenging the reimbursement decision – which, as I have said, is the real target of this claim. In those circumstances, it is not necessary and would not be appropriate to decide whether the first proposition is made out. It may be observed, however, that the claimant's argument depends on deriving a general proposition from *R (Lumba) v Secretary of State for the Home Department* [2011] UKSC 12, [2012] 1 AC 245. Lord Dyson's remarks at [34]-[35] were made in the context of a case concerning a secret policy, at odds with the published policy, governing the exercise of a statutory discretion to detain. Whether those remarks can be transposed to the very different context of a policy guiding clinicians in relation to the decisions made following a clinical assessment about treatment options does not seem to me to be at all obvious.

**Ground 4**

64 The claimant accepts that ground 4 is contingent on establishing that the Council adopted an inflexible policy or practice under which it closed its mind to the possibility of funding an immediate detox for the claimant without having first completed alcohol reduction work. Since I have not accepted the premise, this ground falls away. However, since I heard argument, I should say something about it.

65 The claimant's case depends on five propositions: first, that the reimbursement decision falls within the ambit of Article 8 ECHR; second, that there was a relevant difference in treatment between the claimant and the chosen comparator; third, that the difference was on the ground of "other status"; fourth, that the claimant and the relevant comparator were in an analogous situation; fifth, that the difference in treatment was not objectively justified. The fourth and fifth propositions are linked or, as it is sometimes said, two sides of the same coin.

66 As to the first proposition, it must be firmly borne in mind that the decision alleged to have breached Article 14 is the reimbursement decision. The question is whether that decision falls within the ambit of Article 8 for the purposes of Article 14, in circumstances where the claimant did in fact receive private detox treatment which was successful. In that context, the decision of Foster J in *R (SHU) v Secretary of State for Health and Social Care* [2019] EWHC 3569 (Admin) [2020] 4 WLR 124 is instructive. In that case, the claimants were not ordinarily resident in the UK and so were liable to pay charges for NHS treatment. They sought to challenge the Health Secretary's failure to extinguish their liability to those charges under Article 14, read with Article 8, relying on many of the same authorities as the claimant in this case: see [59]-[76]. The conclusion was that, on the particular facts of the case, the decision not to extinguish the debt did not fall within the ambit of Article 8: see [112]-[117].

67 The approach in *SHU*, based as it was on a careful analysis of the Strasbourg and domestic authorities, requires a focus on the evidence as to the effect of the particular decision under challenge and the interests protected by Article 8. A decision not to reimburse a sum in the order of £19,000 is bound to have some effect on an individual, but the evidence here does not describe any effects of that decision sufficient to establish the necessary connection with the interests protected by Article 8. I would accordingly hold that the decision did not fall within the ambit of Article 8 ECHR for the purposes of Article 14.

68 The second proposition is based on the failure to treat the claimant – as someone with a "genuine clinical need for detox without having first completed an alcohol reduction programme" – differently of patients who are clinically suitable for alcohol reduction work prior to detox. This, the claimant says, is prohibited by Article 14 ECHR on the basis identified by the Strasbourg Court in *Thlimmenos v Greece* (2001) 31 EHRR 15. If, contrary to my findings, the Council had applied a policy incapable of making such a distinction, it would have been necessary for the claimant to establish by evidence that he had the genuine clinical need he claims. Given that he was offered but declined an assessment, and in the absence of any other evidence, I would not have found that established.

69 The arguments in relation to the third proposition are more evenly balanced. Given the Strasbourg Court's broad approach to "other status" (see Lord Reed's observation in *R (SC) v Secretary of State for Work and Pensions* [2021] UKSC 26, [2022] AC 259, at [71], that this requirement "rarely troubles the European court"), the status of suffering from alcoholism so severe that any non-medically assisted alcohol reduction is unsafe is likely to qualify. However, given my findings under ground 1, and at [66]-[68] above, it is not necessary to express a final view about this.

70 The fourth and fifth propositions are different sides of the same coin. However, since the Council accepts and avers that there are situations in which detox without alcohol

reduction work may be indicated, it plainly could not advance a justification under Article 14 for a blanket rule if, contrary to my view, it were required to provide one.

## Conclusion

71 For these reasons, the application to amend will be dismissed and the claim will also be dismissed.