Neutral Citation Number: [2020] EWHC 882 (QB)

Case No: QB-2020-001266

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 09/04/2020

Before :

MR JUSTICE CHAMBERLAIN

- -

Between :

University College London Hospitals NHS Foundation Trust

Claimant

- and -

MB

Defendant

- -
- -

Mr Simon Sinnatt (instructed by **Hempsons**) for the **Claimant**
Mr Russell Holland (instructed directly) for the **Defendant**

Hearing dates: 2, 6 & 9 April 2020

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Approved Judgment

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

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MR JUSTICE CHAMBERLAIN

Covid-19 Protocol: This judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to Bailii. The date and time for hand-down is deemed to be 09.04.2020 at 16:00pm.

Mr Justice Chamberlain :

Introduction

1 The Claimant is the NHS Foundation Trust which operates, among other hospitals, the National Hospital for Neurology and Neurosurgery ("the Hospital"), which is located at Queens Square, London WC1. By a claim issued on Thursday 2 April 2020, the Claimant sought from the Defendant possession of bedroom 3A in the Hughlings Jackson Ward ("the Ward") of the Hospital. I ordered pursuant to CPR r. 39.2(4) that no report of these proceedings may identify the Defendant, who is to be referred to as "MB". The Ward has 12 beds and is intended for those requiring acute neuropsychiatry care for periods of up to 14 days (sometimes extended to 28 days depending on clinical need).

2 The Claimant's possession claim was said to be urgent because the COVID-19 pandemic meant that the bedroom is urgently needed for other patients; and because in any event it is contrary to MB's interests to remain in the Hospital, where she is at increased risk of contracting COVID-19. The Claimant says that MB can be safely discharged to specially adapted accommodation provided by the local authority, Camden London Borough Council ("Camden") with a care package, which the Claimant considers more than adequate to meet her clinical and other needs.

3 The possession claim came before me as duty judge on the day it was issued. I drew the parties' attention to CPR 51Z PD, which stays possessions claims under CPR Pt 55 for a period of 90 days, but which does not apply to claims for an injunction. I then held a telephone directions hearing on the afternoon of 2 April 2020. I heard submissions from Mr Simon Sinnatt for the Hospital and from MB and her sister JU. They indicated that MB wished to be represented. I permitted the Hospital to make an application for an injunction by 12 noon on Friday 3 April 2020 and directed a further telephone hearing at 2pm on Monday 6 April 2020.

4 An application for an interim injunction was made on 3 April 2020. At the hearing on 6 April 2020, MB was represented by Mr Russell Holland, counsel, who was instructed directly. He did not contend that CPR 51Z PD precluded the hearing of the application for an interim injunction. Prior to the hearing, Mr Holland filed a skeleton argument and attached various medical reports. He made helpful and concise oral submissions. His essential case was that MB wished ultimately to be discharged from hospital, but had concerns about the care package offered by Camden. Those concerns were connected to her complex mental health conditions, which amounted to disabilities. If she were discharged while those concerns remained unaddressed, and irrespective of whether the concerns were objectively well-founded, she would be at risk of suicide or self-harm or at least of suffering extreme distress. To discharge her in those circumstances would be contrary to the Claimant's obligations under Articles 3, 8 and 14 of the European Convention on Human Rights ("ECHR") and contrary to ss. 29 and 149 of the Equality Act 2010 ("the 2010 Act").

5 I gave the Claimant permission file evidence to address the claimed effect of discharge on MB's mental health by Wednesday 8 April 2020. I adjourned the hearing of the application for interim relief to Thursday 9 April 2020. I agreed to start the hearing at

12 noon to accommodate MB, who finds it difficult to operate effectively in the morning.

The evidence filed with the claim on 2 April 2020

MB's diagnosis

6 MB was first admitted to the Hospital on 18 February 2019 after collapsing at home. She has a diagnosis of functional neurological disorder manifesting as variable upper and lower limb weakness, variable and intermittent upper limb tremor and speech disturbance. She has chronic migraine, fatigue and generalised pain. She has long-standing, complex psychological conditions, including post-traumatic stress disorder, disrupted attachment, obsessive compulsive disorder and possible borderline personality disorder and Asperger's syndrome. She needs help with personal care, including washing, dressing and toileting.

The care and treatment provided by the hospital to MB

7 The main evidence as to MB's clinical needs comes from Dr Gerry Christofi, a consultant neurologist employed by the Hospital. In a detailed witness statement dated 30 March 2020, Dr Christofi has explained the care and treatment given to MB. She was transferred between wards on a number of occasions. Staff members have endeavoured to make reasonable adjustments to accommodate her disabilities. These include the provision of a side room of which she has sole occupancy, the provision of a 24-hour registered mental health nurse, accommodating MB's preference for certain members of staff to nurse her, scheduling therapy sessions in the afternoon to allow her sister to be present, not waking her before 11 am, the provision of at least four toothbrushes a day in view of her OCD and the provision of notice prior to visits for healthcare professionals, including community partners.

8 MB has been assessed by a number of consultants over the period of her stay at the Hospital. The various investigations performed are set out in full by Dr Christofi. MB and JU have been verbally aggressive towards therapists on a number of occasions.

9 On 8 August 2019, therapists were asked by Camden to provide a one-off assessment and opinion in relation to referral to community therapy post-discharge. MB declined to participate in the assessment, which was rearranged to 12 August 2019. When the assessment session took place, it was terminated prematurely as MB was verbally aggressive and accusatory towards staff. The therapists indicated that they felt threatened and uncomfortable. Cognitive behavioural therapy was arranged. This began on 26 September 2019 but was terminated on 27 September 2019 at MB's request.

10 Dr Christofi describes MB's behaviour as follows:

> "41. Unfortunately, due to [MB's] behaviour, functional process has been severely hampered during her admission. [MB] will frequently use threatening behaviour towards the healthcare professionals involved in her care. She has shouted at staff on multiple occasions, sworn at them, accused many of us of lying, harassing and bullying her. She has questioned the professional integrity and motives of staff and accused us of being in

> collusion with management and local authority to bully and harass her. She has referred to one of our senior matrons as 'Hitler'. Conversations have been recorded both overtly (often despite protest) and covertly. Atmosphere has been intimidating, adversarial, calumniating and extremely unpleasant. Several examples are documented in appended to this statement. [MB] has frequently threatened court action, often referring to staff including myself of negligence that's risking a professional registration.
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> 42. [MB] has accused staff of precipitating these outbursts, which she says or due to her mental health conditions, including PTSD. These episodes have impacted negatively upon the mental health of several staff members, including my own. Accordingly, staff are receiving support from the trust staff psychology and welfare services. A recent consultation from the head of staff psychology and welfare service stated that 'most staff meet the threshold for needing therapeutic support for their own mental health, as there are reports of symptoms would qualify for interventions for anxiety, depression, stress, burnout and PTSD at the very minimum'.
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> 43. Furthermore, [MB's] sister has repeatedly been verbally aggressive and threatening towards staff, including myself. She has threatened to take staff members to court. There have been multiple unsolicited emails to members of clinical and management teams. Many of the emails have been accusatory, making staff feel pressurised to provide a prompt response and often feeling threatened."

The care package

11 Discussions relating to MB's care package have been ongoing for more than a year. Originally, a care package was agreed involving daily care four times per day (two carers each time). All equipment, including a hospital bed, mattress, commode and bedpan were delivered to MB's ordinary residence on 12 March 2019. MB declined the care package offer. The Claimant's therapy staff considered whether MB had capacity to do so and concluded that she did. On 30 May 2019, a professional meeting was held between the clinical team at the Hospital and the clinical commissioning group for Camden. In view of the fact that the proposed care package did not include 24-hour care, attempts were made to withdraw the registered mental health nurse the following day. This led to challenging behaviour by MB. MB and JU were verbally aggressive towards staff. The registered mental health nurse was reinstated.

12 There was a further meeting on 13 June 2019, at which other avenues were explored, including transition to a care home. On 20 June 2019, MB declined to be discharged to a care home. On 2 July 2019, MB indicated that she was willing to consider moving to ground floor accommodation, but only with 24-hour care. On 3 July 2019, the local authority rejected her proposal for 24-hour care. On 22 July 2019, the local authority approved funding for an overnight, awake carer and a four times daily package of care for two weeks after discharge, with an assessment at home. On 31 July 2019, MB declined to cooperate with discharge planning and advised the trust that they would need to issue court proceedings to facilitate her discharge. On 1 August 2019, an attempt was made to discharge MB from the Ward. She refused to leave. A letter was

given to her informing her that she no longer had a license to occupy a bed at the hospital. Again, she refused to leave.

13 On 12 August 2019, the Hospital's transport manager assessed the building access at MB's ordinary residence and advised that she could not be discharged there on a stretcher, given that she was bedbound. Camden's housing manager then identified a property that could be occupied under temporary license. MB declined that property stating that the temporary tenure offered would be detrimental to her mental health. After a further assessment by a consultant psychiatrist on 27 September 2019, it was agreed that it could have a detrimental impact on MB's health if she were offered temporary accommodation. The local authority therefore agreed to explore the possibility of permanent housing. On 7 October 2019, a professional meeting was held with the local authority. Camden indicated that there were no vacant wheelchair-accessible properties and it was possible that none would be available for several months. On 31 October 2019, a property became available at Kiln Place. MB and her sister visited. MB accepted the property in principle, pending agreement by the local authority to carry out a number of adaptations before she moved in. There were then delays caused by the need to obtain planning consent.

14 On 11 March 2020, MB met officials from Camden and signed the tenancy agreement. The tenancy start date was 13 April 2020. This was to allow Camden to undertake some of the works that she had requested. The hospital was informed on 16 March 2020 by Camden that the property was ready for occupation. The care package offered by Camden involved 24-hour care, 7 days a week for a month, followed by an assessment to review ongoing needs. MB insisted, however, that she would not leave the hospital until she received a guarantee of 24-hour care for at least one year before review. She was concerned that the assessment would be used to reduce or withdraw her care.

<u>The evidence as to the relevance of the Covid-19 pandemic</u>

15 Dr Christofi explained as follows in his witness statement of 30 March 2020:

> "67. Since [MB] signed the tenancy agreement, the situation at [the Hospital] and within UCL H as a whole, has changed dramatically due to the COVID-19 pandemic. We are now in desperate need of beds for patients unwell with COVID-19 and all patients who are medically fit for discharge are being discharged home or into other care arrangements that are deemed safe, as per the Government's guidance dated 19 March 2020 (annexed to this statement).
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> 68. 19 March 2020, [MB] was transferred to [the Ward], a neuropsychiatric ward at [the Hospital]. The ward is not currently actively treating patients and is an outlying neurology ward. She was moved there as part of bed management due to the COVID-19 pandemic. [MB] cooperated with this move.
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> 69. On 19 March 2020, [MB] was informed by way of a written discharge notice that [the Hospital] intended to discharge her to her new flat on 23 March 2020, with the proposed package of care. It was explained that discharge was being expedited due to the COVID-19 pandemic and with

> [MB's] best interests in mind. Despite staff communicating the information to [MB] as sensitively as possible, [MB] stated that she would not leave [the Hospital], stating that she 'would rather die from COVID-19 infection than be subject to more mental torture or harassment by UCLH'.
>
> 70. On 23 March 2020, [MB] was issued with a letter terminating her license to remain at [the Hospital]. Again, she stated that she would not leave.
>
> 71. [MB] has also cancelled the delivery of all equipment to her flat in Kiln Place after locating details of the delivery company. Furthermore, she is refusing to hand over the keys for her flat to the local authority or UCLH so that they are able to arrange for the equipment to be installed.
>
> 72. We have been informed that the Local Authority intend to start the 24/7 care package as of Thursday, 26 March 2020.
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> 73. It is of paramount importance that [MB] is discharged from [the Hospital/UCLH] immediately. Not only do we need the beds for critically unwell patients, but remaining in a hospital environment places [MB] at unnecessary risk of contracting COVID-19. It is therefore undoubtedly in [MB's] best interests to be discharged to a safer location urgently."

16 The guidance referred to by Dr Christofi in his paragraph 67 emphasises the need, in the light of the current emergency, to discharge all patients who can be cared for at home.

17 Dr Christofi went on to explain that, in his view the current package of care offered by Camden, involving as it does 24-hour care seven days per week, is reasonable, though he noted that it is crucial that [MB] has ongoing support for her mental health issues and to enable her to adjust to her new accommodation. He added this:

> "The risks of remaining in hospital certainly far outweigh any risks moving into her flat earlier than [MB] originally anticipated."

18 Dr Christofi noted, finally, that [MB's] ongoing dispute "lies with the local authority and the provision of care offered in relation to the timing of reviews". In relation to this, he indicates that Camden has agreed to extend its offer of 24/7 day care to 3 months before a review but it will not agree to accommodate [MB's] request for this level of care to be guaranteed for 12 months.

MB's position at the hearing on 6 April 2020

19 As I have indicated, the care package now offered by Camden includes 24 hour a day, 7 day a week care. This is what MB herself said should be provided when she refused to accept the original care package offered. Camden have now agreed that this care package will remain in place for 3 months, pending a review.

20 At the hearing on 6 April 2020, Mr Holland explained that MB has a number of concerns with this care package. They are as follows:

(a) The review to be carried out during the first three months could conclude that a different package is appropriate, so the care package should be guaranteed for 12 months.

(b) There is a need for the therapy provided as part of the care plan to be provided by "independent therapists" – that is therapists independent of Camden, because MB no longer trusts Camden.

(c) Some adaptations to the flat are required to accommodate MB's disabilities: in particular, the installation of a dimmer switch (which is required because of MB's migraines), a shower screen and a canopy over the front door so that those entering do not bring water into the flat and a "deep clean" of the premises to be supervised by her sister JU (the latter three are requirements associated with MB's OCD).

21 MB's case, as presented by Mr Holland, is that MB wishes to leave the Hospital, but only once her concerns about the care package and the accommodation to which she is to be discharged have been addressed. Mr Holland submitted that, unless these concerns are addressed to MB's satisfaction, she will – as a result of her mental health conditions, which are disabilities – suffer extreme distress, which may lead to self-harm or suicide. This was so whether or not the concerns were, in an objective sense, justified. Mr Holland refers to passages in medical notes and reports to support his submission as to the likely effect that discharge will have if MB's concerns are not addressed to her satisfaction.

22 More generally, Mr Holland submitted that, pending resolution of her concerns, the decision to require MB to leave the Hospital involved a breach of her rights under Article 3 ECHR (because, in the light of her particular mental health conditions, it was likely to precipitate extreme distress, and possibly self-harm or suicide, at a level that would reach the high threshold for "inhuman and degrading treatment") and/or Article 8. In addition, he submitted that, insofar as the decision involved discrimination against MB on the ground of her disability contrary to Article 14 (read with Articles 3 and/or 8) ECHR and contrary to s. 29 of the 2010 Act. As to that, it was said that the decision involved a breach of the duty to make reasonable adjustments.

23 The evidence supporting Mr Holland's submissions consisted of a witness statement from MB's sister, JU. In that statement she explains why, in her view, MB developed the complex mental and physical disorders from which she suffers. JU refers to a history of cruelty and neglect, which she says MB suffered at the hands of her father. Her mother, who was mentally unwell, was repeatedly physically assaulted by her father. MB experienced instability in her early childhood when her abusive father removed her from her mother and moved her between the UK and Bangladesh. MB's eldest brother has been in what JU describes as a "psychiatric institute" for over 20 years with a very poor prognosis. JU indicates that she is now "seeking the courts help to protect my sister and help her get better with the right treatment and support". If such treatment and support is not provided, JU says, "the only option I will be left with is to leave this world".

The Claimant's further evidence filed on 8 and 9 April 2020

24 In a further witness statement dated 8 April 2020, Dr Christofi addressed the submission advanced on MB's behalf that discharge in circumstances where MB's concerns about her care package and accommodation are not addressed to her satisfaction would be likely to cause extreme distress and could precipitate self-harm or suicide.

25 Dr Christofi pointed out that the claimant has no control over any aspect of MB's care package. Decisions about the frequency of reviews, the therapists involved or the adaptations that will or will not be carried out are for Camden. Dr Christofi explained that the hospital is satisfied that discharge is appropriate, notwithstanding the concerns raised by MB.

26 In order to address the potential effect of discharge on MB's mental health, Dr Christofi spoke to Dr Gary Price and Dr Panayiota Petrochilos, two consultant neuropsychiatrists who have been involved in MB's care. Dr Petrochilos's view (with which Dr Price agrees) is as follows:

> "[MB's] case is that because of her disabilities harm would be caused to her (as a minimum severe distress and potentially self-harm or suicide) if she were forced to leave the hospital without the assurances that she needs in respect of her future care and treatment.
>
> Her current physical needs/dependencies have been factored into her current care package – to assure comfort.
>
> Her mental health needs are being considered by her local CDAT [Complex Depression, Anxiety and Trauma] team and care coordinator (who has visited her at [the Hospital]), local psychiatry consultant and she has access to mental health Crisis services as every other service user. This is available by telephone and they visit people at home so access is possible.
>
> It is not appropriate for us to provide assurances about future commitments and provision for care from other authorities. Provision of ongoing care will need to be subject to review. Making commitments that cannot be satisfied is likely to be further detrimental.
>
> It is unlikely that [MB] can ever be fully reassured as she does not trust hospital authorities, council and possibly other authority figures – this is something that professionals and [MB] have had to manage. There is no current intervention that can rectify that. Hence expecting that [MB] will be satisfied and agree to discharge is not a realistic endpoint.
>
> Regarding risk: She is not at risk of harm from others; there is no intrinsic harm caused to her by her disabilities; no one can guarantee that she won't harm herself. However, based on the facts, we are satisfied that despite threats to harm over the years, they have been no episodes related to this. There have been no previous self-inflicted risk incidents that would reliably indicate that she poses any such risk to herself. Nevertheless, in the case of

any such future episode, it would be managed in the same way as any other service user (see above for equity of access to crisis team)."

27 Dr Christofi addressed each of MB's concerns about her care package and accommodation. In relation to these, he responds as follows:

(a) Dr Christofi has been aware for some time of MB's concerns about the reviews to be carried out by Camden of her care package. He and his colleagues have taken these concerns seriously, but "do not consider that a serious decline in [MB's] mental health is likely provided that she has the appropriate support following her discharge". Dr Christofi believes that the 24-hour care package for the first three months is appropriate. It will ensure the MB has carers with her at all times. This is particularly important during the initial settling in period at the flat when the risk of mental distress is likely to be at its highest. The CDAT team have also agreed to see MB on discharge and the local authority has confirmed in writing that this support will be provided. Dr Christofi asked the CDAT team to update its risk assessment. It has done so and assess the risk of suicide as "currently moderate to low", but notes that MB is monitored constantly, so the risk is managed. The assessment includes a risk management plan, setting out what will be done if MB's mental health deteriorates. Dr Christofi is satisfied that support from the CDAT will minimise any risks to MB's mental health and well-being and that if additional mental health support is required, the CDAT will be well placed to arrange this.

(b) Dr Christofi was unaware until 6 April 2020 that MB had asked for independent therapists to be involved in her care. Her care package is provided by an agency, Supporting Care, which he describes as "her care agency of choice". Dr Christofi explains that the identity of the therapists is a matter for Camden, but notes that, should Camden feel it appropriate to refer MB for community therapy, senior therapists from the hospital have offered to liaise with the community therapy team you to advising on how a limited program might be incorporated into MB's routine following discharge.

(c) As to the adaptations sought by MB, Dr Christofi indicates that dimmer switches and a shower screen have been installed in the bedroom and living room of her accommodation and exhibits photographs demonstrating this. Camden has indicated that a deep clean was carried out at the flat on 23 March 2020 and that JU was present for part of the time when this was being done. It has, however, refused to install a canopy above the door. Dr Christofi indicates that in his view the installation of a canopy is not essential from a mental health perspective.

28 It had been hoped that Dr Christofi would be available at the hearing to give oral evidence if that was required. On the morning of 9 April 2020, however, a further witness statement was filed by the solicitor with conduct of the case indicating that that would not be possible because, as a result of staff shortages, he was required to work in the neurological intensive care unit, one of the Claimant's designated COVID-19 wards. Dr Price was, however, made available instead, though it was not necessary to hear oral evidence from him. He had had a number of meetings with MB over the course of the last year. He interviewed MB again on 8 April 2020 to assess her mental

state. His conclusions were set out in a letter of that date, in which he described the interview.

29 Dr Price explained that MB told him that if she is evicted from the hospital and is not provided with an independent neuro physiotherapist, an independent occupational therapist and an independent psychologist for at least a year, she would kill herself. This was because without these therapists she would end up in a "vegetative state" and would rather kill herself before this happens. MB said that her sister had physically prevented her from killing herself in the past. Having a care package review every month made her anxiety worse and this would also lead to deliberate self-harm. She stressed the need for various adaptations at home, including the dimmer switch, canopy over the front door and shower screen. Unaddressed adaptation issues would cause her anxiety and uncertainty and might also lead to her suicide. If any repair workers come to her home she would have to be accommodated somewhere else.

30 Dr Price went on to say this:

> "**Summary**
>
> She threatens to kill herself if she does not receive the community care package she wants. This care package is at odds to what is available or suggested. She cites her mental health problems as a reason for anxiety and consequently the need for this care package. Anxiety around her local authority care review appears to be her main concern although she also cites anxiety around OCD as a symptom.
>
> **Risk Summary**
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> …
>
> With regard to risks of self harm, she has no biological features of depression such as sleep disturbance or loss of appetite. She engages in activities such as watching films on her laptop. No psychotic symptoms have been observed (relating to hearing voices, nihilistic delusions etc over the time she has been in hospital). Her plans for DSH [deliberate self-harm]/suicide and not in the context of depression. Her history suggests threats of DSH when her needs are not met.
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> With regard to her ongoing mental health needs, these fall under the local CDAT team with a care coordinator (who has visited her at [the Hospital]) she has access to local mental health crisis services.
>
> I have written to CDAT about her anxieties but I cannot guarantee assurances about future commitments from them. They must be free to make that conclusions about treatment in the long and short-term.
>
> At present she will not engage in discussing her 'suicide' plan and so collaborative work around trying to reduce the risk of DSH cannot take place. Consequently suicide is expressed as an ongoing threat and nothing can be done to address it other than agreeing to all her requests. It is also

> unlikely that she can ever be fully reassured as she does not trust the hospital or the local authority.
>
> She may well try DSH if she found herself in a situation where her perceived needs are not met and I cannot predict with certainty that she will not harm herself. However, it is important to note that despite threats in the past, there had been no previous TSH incidents following threats. A past history of DSH is useful in informing on future risk. If there are any future episodes of DSH, this should be managed by her local mental health service. In that regard, we would therefore need to involve local this is including CDAT closely at the time of discharge."

31 In a second letter, also dated 8 April 2020, Dr Price added this:

> "I have read through my letter to you that I have just written in the notes. In that letter I addressed risks of DSH in this lady. What I possibly did not make clear was that there are no mental health reasons I can think of to keep her in this hospital. We will of course liaise with her own mental health team in discharge planning."

The telephone hearings

32 It is clear both from the written evidence before me and from her conduct during the two telephone hearings on 2 and 6 April 2020 that MB exhibits challenging behaviour. On several occasions during the hearings before me on those dates, she engaged in long, shouted explanations about her needs, as she perceives them. At times, she refused to allow others (including me) to interrupt her. She clearly finds it difficult to understand the effect her behaviour has on others. I accept that this behaviour is caused by or connected with her mental health difficulties, which are disabilities within the meaning of the 2010 Act and for the purposes of Article 14 ECHR. I have borne that carefully in mind.

33 In order to ensure that the final hearing of the Claimant's application for interim relief was effective, it was it necessary to make clear in the hearing on 6 April 2020 that, when the telephone hearing resumed on 9 April 2020, submissions would be made by MB's lawyer on her behalf and no interruptions by MB or by JU would be permitted.

34 The hearing on 9 April 2020 was conducted in an orderly way using a telephone conferencing service. It was in public. A member of the press and a law reporter attended. Concise and helpful submissions were made by Mr Sinnatt and Mr Holland. There was a break after Mr Sinnatt had concluded his submissions to allow Mr Holland to discuss matters with MB and JU, so that Mr Holland's submissions could be fully informed by instructions from MB. Among their other submissions, Mr Sinnatt and Mr Holland each addressed a series of questions of law and authorities identified by me as relevant and sent to them by email prior to the hearing.

MB's position at the telephone hearing on 9 April 2020

35 Mr Holland expanded briefly on his written submissions. He maintained the position that it was inappropriate to grant interim relief. MS's concerns had still not been

addressed to her satisfaction. Camden had not set out with sufficient clarity the identity of those who would be providing therapy and when that therapy would be provided. This was important to someone with MB's particular mental health difficulties. The lack of certainty caused her extreme distress. There was a further issue not mentioned on 6 April 2020. Camden had given keys to the flat to various individuals who had to enter to clean it and make alterations but they had not given MB a list of these individuals. This was an additional source of distress. MB should be afforded the opportunity to file independent evidence as to the likely effect on her of discharge, which – she maintained – would be likely to cause extreme distress and possibly self-harm or suicide.

36 If an order was to be made, it was important that there should be clarity as to how it was to be implemented, given that MB would not consent to be moved while her concerns were unaddressed.

The legal framework

37 The Claimant brings this claim to enforce its private law rights as property owner. As a matter of private law, MB became entitled to occupy the room she is currently in because the Claimant permitted her to do so by admitting her to the Hospital. The Claimant has now terminated her licence to occupy that room. It follows that she is now a trespasser. Ordinarily, the Claimant would be entitled to seek an order for possession pursuant to CPR Pt 55: see e.g. *Barnet Primary Care Trust v H* [2006] EWHC 787 (QB), (2006) 92 BMLR 17 (Wilkie J); *Sussex Community NHS Foundation Trust v Price* (HHJ Coe). That is not currently possible because of the general stay on possession claims effected by CPR 51Z PD. The stay does not, however, affect claims for injunctions: see para. 3 of the Practice Direction. A property owner is in general entitled to an injunction to enforce its rights as against a trespasser: see the decisions of the Court of Appeal *Manchester Corporation v Connolly* [1970] Ch 420 and Supreme Court in *Secretary of State for the Environment, Food and Rural Affairs v Meier* [2009] UKSC 11, [2009] 1 WLR 2780. A hospital is no different from any other proprietor in this regard.

38 In this case, the Claimant's application is for an interim injunction, but the effect of such relief, if granted, would be tantamount to final relief. That does not preclude absolutely the grant of such relief, but it does mean that I should not grant it unless satisfied that there is *clearly* no defence to the action: Sir David Bean et al., *Injunctions* (13th ed., 2013), §3-38. The balance of convenience and other discretionary factors must also be considered.

39 As Mr Sinnatt accepted, it would be wrong to grant injunctive relief to enforce MB's discharge from hospital if there were an arguable case that the Hospital's decision to cease to provide in-patient care had been taken in breach of its public law obligations. It is well established that such a breach can be relied on by way of defence to private law proceedings: *Wandsworth v Winder* [1985] AC 461. In this case, MB contends that the Hospital's decision to terminate her licence to occupy room 3A breached her rights under Articles 3, 8 and 14 ECHR and its obligations to her as a disabled person under the 2010 Act.

My conclusions

MB's capacity to defend these proceedings

40 In his first witness statement, Dr Christofi said this:

> "My colleagues and I have considered whether MB has capacity to make her own decisions and we are all in agreement that she does and we have no concerns about her capacity."

41 Nothing said by Mr Holland indicated any doubt about MB's capacity. I have accordingly proceeded on the basis that MB has full capacity to take decisions about her discharge from the Hospital and her care package post-discharge and to take the decisions necessary to defend these proceedings.

Is there a need for further evidence?

42 The medical evidence before me comes from one party to this claim, namely the Claimant. MB submitted that I should not consider the claim for interim relief without adjourning to allow an opportunity for her to obtain her own independent medical evidence. In my judgment, that would not be appropriate, for three reasons – two of principle and one of practicality.

43 First, a decision by an NHS hospital not to provide in-patient care in an individual case might, in principle, be challengeable on public law grounds by judicial review if the decision were tainted by improper purpose or had been made in breach of statutory duty or otherwise contrary to law. But, if such a decision were taken on clinical grounds, it would not be open to a claimant in such proceedings to adduce expert evidence with a view to impugning the clinical basis of the decision. Any attempt to adduce such evidence for that purpose would go well beyond the limited circumstances in which expert evidence is admissible in judicial review proceedings: see e.g. *Law Society v Lord Chancellor* [2019] 1 WLR 1649, [36] *et seq*. These are not, of course, judicial review proceedings, but insofar as MB seeks to raise collateral challenges to the Hospital's clinical judgment by way of public law defences, it is difficult to see why the court should be prepared to entertain evidence that would not be admissible on a direct challenge.

44 Second, clinicians cannot be required to provide treatment or care contrary to their own clinical judgment: In *Re J (Wardship: A Minor)* [1991] Fam 33. Dr Christofi's careful evidence shows that it is the considered view of the treating team that MB does not require hospital care and can safely be discharged. It would be quite wrong for the court to entertain expert evidence with a view to compelling them to continue to provide that care, even if other clinicians may take a different view as to what is clinically indicated.

45 Third, and most importantly, to the extent that there are issues in this claim to which independent expert evidence could in principle be relevant (such as the immediate effect of discharge on MB's mental health), the COVID-19 emergency means that there is no prospect of obtaining such evidence within a reasonable timeframe. If I were to adjourn this matter to enable MB to file her own independent expert evidence, the practical effect would be to delay her discharge for a considerable period at precisely

the time when her bed is most needed by other patients, thus defeating the purpose of this application. That being so, I have to consider in the exercise of my case management discretion whether I can properly proceed to determine this application for interim relief without affording MB the opportunity to file independent expert medical evidence. I have concluded that I can. Although it is obvious that neither Dr Christofi's evidence does not comply with the requirements of CPR Pt 35 (because he is employed by one of the parties), his two statements are detailed and balanced. The views there expressed reflect the conclusions reached on a range of topics by an impressive multi-disciplinary clinical team. The further, recent evidence of Dr Petrochilos and Dr Price (albeit provided indirectly rather than in witness statements) provide further reassurance that the impact of discharge on MB's mental health has been carefully considered and assessed. In the unusual circumstances in which this application is made, I have no hesitation in concluding that it is neither feasible nor necessary to adjourn to permit MB to file independent expert evidence (even if expert evidence would have been admissible at a final hearing).

What the evidence shows about the effect of discharge on MB's health and safety

46 On the basis of all the evidence and submissions to date, my conclusions can be expressed briefly as follows:

(a) There is no dispute, and in any event no basis for any dispute, that MB's physical healthcare needs can be satisfactorily met at home with the care package currently promised by Camden, which includes 24-hour care.

(b) Because of MB's complex constellation of mental health conditions, she finds it difficult to trust those from the Hospital and local authority who provide care to her and frequently exhibits abusive and challenging behaviour.

(c) Considerable efforts have been made by Camden to accommodate and address her concerns. They have not yet been addressed to her satisfaction. However, given (b) above, it is unrealistic to suppose that they will ever be addressed to her satisfaction in the foreseeable future.

(d) MB uses threats of self-harm and suicide to persuade others to give her what she considers she needs. There are, however, no known instances of her resorting to self-harm.

(e) It is not impossible that MB will try to commit suicide or resort to self-harm if discharged. But on the evidence the risk of this is moderate to low. More importantly, it is appropriately managed by the provision of 24-hour care and the availability of specialist mental health support.

(f) It is likely that MB will suffer from extreme distress if discharged now, while her concerns have not been addressed to her satisfaction. But this too is capable of being managed by 24-hour care and the availability of specialist mental health support.

MB's concerns about the care package currently offered by Camden

47 Before considering the public law defences to this claim, it is necessary to say something about the concerns expressed by MB about the care package currently offered. The first such concern is not one that it could be reasonable to expect Camden to accommodate. Local authorities are both entitled and obliged periodically to review the care needs of those for whom they are obliged to make provision. Individuals in receipt of care packages are not entitled to insist on the level of care they believe they need. In this case, Camden has in fact agreed to provide the level of care MB believes she requires (24 hour care, 7 days per week) for an initial period of 3 months. I understand that MB's particular mental health difficulties make her more distressed than others might be about the prospect that her care package may be altered to her detriment after that, but it must be borne in mind that any such decision would itself be subject (in principle) to judicial review if flawed by any public law error.

48 As to MB's second concern, there is no suggestion that those providing therapy as part of the care package are other than properly qualified to do so. Again, I well understand that this concern too is connected to her mental health conditions, which have caused her to lose trust in many of those providing her care. Nonetheless, MB is not entitled to insist on therapists of her choosing. The identity of the therapists is a matter for the local authority, to be determined in the light of any relevant clinical advice.

49 As to the adaptations sought by MB, I again appreciate that what may appear minor to others are not minor to MB and that this is in part a result of her disabilities in general and her OCD in particular. Nonetheless, very great efforts have already been made to accommodate MB's needs, as she perceives them. If Camden's conduct in the past is a reliable guide to its conduct in the future, it will deal sensitively with any further requests for adaptations or alterations. This does not mean that I expect it to acceded to any such request, however unreasonable. There is no medical evidence to support the suggestion that the one adaptation which evidence suggests Camden has refused to provide (the rain canopy) is so critical as to make discharge impossible until it has been undertaken. Dr Christofi's evidence is directly to the contrary. MB's own perception that this adaptation is critical does not make it so.

50 The additional concerns raised for the first time in the hearing on 9 April 2020 are not ones that Camden could realistically be expected to accommodate. Camden has set out the care package to be offered in sufficient detail. It is not reasonable to expect Camden to give identify the particular individual who will provide care or the precise dates when they will provide it, particularly in the context of the current emergency. The need to give keys to contractors arises precisely because of the adaptations upon which MB has herself insisted. A list of those to whom keys have been given can no doubt be provided, but the request for such a list to be compiled before discharge is not feasible or reasonable. The fact that this concern was not raised until today confirms Dr Petrochilos's assessment that the nature of MB's condition is such that the point may never be reached when MB's concerns have all been addressed to her satisfaction.

Private law claims and public law defences

51 Patients have no right to occupy beds or rooms in hospitals except with the hospital's permission. A hospital is entitled as a matter of private law to withdraw that permission. In deciding whether to withdraw permission, the hospital is entitled and indeed obliged to balance the needs of the patient currently in occupation against the

needs of others who it anticipates may require the bed or rom in question. Unless its decision can be stigmatised as unlawful as a matter of public law, there is no basis for the court to deny the hospital's proprietary claim to restrain the patient from trespassing on its property. Where what is sought is an interim injunction which would effectively determine the claim, it is necessary for the court to be satisfied that there is *clearly* no public law defence to the claim; and the balance of convenience and other discretionary factors must also be considered.

Is it clear that MB has no public law defence to this claim?

52 Mr Holland, for MB, did not in terms suggest that the decision of the Hospital to cease to provide in-patient care for MB, and accordingly to require her to leave, was irrational in the *Wednesbury* sense. Any suggestion to that effect would be unsustainable. Dr Christofi's statements demonstrate that he and his team have shown considerable patience and forbearance in their dealings with MB. They have done everything in their power to secure her discharge to a placement which addresses her concerns, even though some of these concerns are unreasonable ones. They have at all stages been sensitive to the need to manage the symptoms and cater for the complex needs associated with her disabilities, even though doing so has adversely affected the health and wellbeing of the clinical staff looking after her. In the light of the detailed evidence in Dr Christofi's statements, there is no prospect whatsoever that MB could establish that the decision to require her to leave is irrational.

53 So far as Article 3 ECHR is concerned, Mr Holland's submissions amount to this: if it can be established that, unless her concerns are addressed, discharge will precipitate suicide, self-harm or extreme distress rising to the level of severity necessary to qualify as inhuman or degrading treatment within the meaning of Article 3 ECHR, the Hospital is legally precluded from discharging her until those concerns are met, even if her concerns are, from an objective clinical point of view, unreasonable and unwarranted. I cannot accept that proposition.

54 It is a tragic feature of MB's complex constellation of mental health difficulties that she frequently suffers from extreme distress, whether she is in hospital or not. But, if the Hospital were precluded from doing anything which might precipitate such distress, it would soon end up in a situation where it was legally precluded from taking *any* step other than in accordance with MB's wishes. In this case, MB would be entitled to insist on the provision of whatever *she* considers she needs as a condition of discharge from hospital, even if the result of her doing so were that the needs of others could not be met. That is not the law, because her needs are not the only ones that the law regards as relevant.

55 In some circumstances, a hospital may have to decide which of two patients, A or B, has a better claim to a bed, or a better claim to a bed in a particular unit, even ceasing to provide in-patient care to one of them to leave will certainly cause extreme distress or will give rise to significant risks to that patient's health or even life. A hospital which in those circumstances determines rationally, and in accordance with a lawful policy, that A's clinical need is greater than B's, or that A would derive greater clinical benefit from the bed than B, is not precluded by Article 3 ECHR from declining to offer in-patient care to B. This is because in-patient care is a scarce resource and, as Auld LJ put it in *R v North West Lancashire Health Authority ex p. A* [2000] 1 WLR 977, at 996,

> "[i]t is plain… that article 3 was not designed for circumstances… where the challenge is as to a health authority's allocation of finite funds between competing demands". Decisions taken by a health authority on the basis of finite funds are, in my judgment, no different in principle from those taken by a hospital on the basis of finite resources of other kinds. In each case a choice has to be made and, in making it, it is necessary to consider the needs of more than one person.

56 The present situation does not involve a comparison of the needs of two identified patients. But the decision to withdraw permission for MB to remain in the Hospital is still a decision about the allocation of scarce public resources. Decisions of this kind are a routine feature of the work of hospitals and local authorities, even when there is no public health emergency. The fact that we are now in the midst of the most serious public health emergency for a century is likely to accentuate the need for such decisions. The absence of evidence identifying a specific patient or patients who will be disadvantaged if MB remains where she is does not mean that such patients do not exist. It is important when considering human rights defences in cases of this sort not to lose sight of that.

57 Analytically, the reason why a decision to require a patient to leave a hospital is unlikely to infringe Article 3 ECHR is because it is based on a prior decision not to provide in-patient care. Such a decision engages the state's positive (and limited) obligation to take steps to avoid suffering reaching a level that engages Article 3, rather than its negative (and absolute) obligation not itself to inflict such suffering. Where the decision to discontinue in-patient care involves the allocation of scarce public resources, the positive duty can only be to take *reasonable* steps to avoid such suffering: cf *R (Pretty) v Director of Public Prosecutions* [2002] 1 AC 800, [13]-[15] (Lord Bingham). It is difficult to conceive of a case in which it could be appropriate for a court to hold a hospital in breach of that duty by deciding, on the basis of an informed clinical assessment and against the background of a desperate need for beds, to discontinue in-patient care in an individual case and, accordingly, to require the patient to leave the hospital. The present is certainly not one.

58 In any event, even if the question were simply whether discharge in current circumstances would lead to suffering rising to the level of severity required to engage Article 3 ECHR, the answer – on the evidence before me as a whole and in the light of Dr Christofi's second statement and the views of Dr Petrochilos and Dr Price – is that it will not. I have no doubt that discharge will be distressing for MB, the risk of a suicide attempt or self-harm, though not negligible, is moderate to low. More importantly, given that she will have 24 hour care, any deterioration in MB's mental health will be picked up. Specialist mental health support can and will be provided by the CDAT.

59 So far as an argument based on Article 8 ECHR is concerned, the difficulties facing MB's argument are even more pronounced. In *R (McDonald) v Royal Borough of Kensington and Chelsea* [2011] UKSC 33, [2011] HRLR 36, Lord Brown said this at [16]:

> "the clear and consistent jurisprudence of the Strasbourg Court establishes 'the wide margin of appreciation enjoyed by states' in striking 'the fair balance … between the competing interests of the individual and of the community as a whole' and 'in determining the steps to be taken to ensure

> compliance with the Convention', and indeed that 'this margin of appreciation is even wider when … the issues involve an assessment of the priorities in the context of the allocation of limited state resources'".

Even though the decisions to cease to provide in-patient care to MB and to require her to leave plainly interfere with MB's right to respect for private and family life, the evidence adduced by the Claimant amply demonstrates that the interference was justified in order to protect the rights of others, namely those who, unlike MB, need in-patient treatment. Bearing in mind the broad discretionary area of judgment applicable to decisions of this kind, there is no prospect that MB will establish the contrary.

60 Nor does reliance on Article 14, read with Article 3 or Article 8, take matters any further. The decision to decline in-patient care to MB does not discriminate against her on the ground of her disabilities. The Hospital has treated her in the same way as a patient with different disabilities or with none: it has determined whether to continue to offer her in-patient care on the basis of her clinical need for such care. To the extent that this is itself discrimination against those, like MB, whose disabilities make them perceive a need for things (such as a rainwater canopy outside the front door) for which there is in fact no objective need, the discrimination would be justified even outside the context of a public health emergency. In the context of such an emergency, there is no prospect that a challenge based on Article 14 in these circumstances could possibly succeed.

61 As for MB's arguments under the 2010 Act, these too are without merit. Compliance with the duty in s. 149 of the 2010 Act is a matter of substance, not form. The fact that there has been no express reference to that duty does not matter. What matters is whether the factors required to be considered have been considered, insofar as they are relevant to the function in question. Here, the function is that of deciding whether to cease to provide in-patient care to MB. That decision was taken on the basis of the careful assessment of Dr Christofi and other members of the multi-disciplinary team. The assessment paid the fullest possible attention to the complex needs arising from MB's physical and mental disabilities. The contrary is not arguable. To the extent that it is said that the decision discriminates against MB on the ground of her disabilities contrary to s. 29 of the 2010 Act, any such discrimination is justified for the same reasons as given in relation to Article 14. To the extent that the complaint is one of failure to make reasonable adjustments, the history demonstrates that Dr Christofi and his team have made every possible reasonable adjustment. The further adjustments to the care package now sought are, for the reasons I have given, not reasonable. There is therefore no arguable claim under the 2010 Act.

62 For these reasons, it is clear, even at this interlocutory stage, that MB has no sustainable public law defence to this claim. If MB had filed a claim for judicial review challenging the decision to cease to provide in-patient care to MB and require her to leave the Hospital, I would have refused permission and certified the claim as totally without merit.

Balance of convenience and discretionary factors

63 Finally, it is necessary to consider the balance of convenience and any other factors relevant to the exercise of my discretion whether to grant the relief sought on an interim

basis. As I have said, because this is an interim application, I have asked myself whether it is *clear* that there is no defence to the Claimant's case. In my judgment, it is clear. This inevitably skews the balance of convenience in the Claimant's favour.

64 But even if MB's public law arguments had a real prospect of success, the ordinary balance of convenience (see *American Cyanamid v Ethicon* [1975] AC 396) would still, in my judgment, fall decisively in the Claimant's favour. On the one hand, the consequence of relief being granted is that not that MB will be left without care. She will have 24 hour professional care, provided in specially adapted accommodation, with planned support from the CDAT team for her mental health needs. In case her mental health deteriorates, there is a suite of further support which can be provided, including (should this be necessary) admission to a psychiatric unit. On the other hand, in the context of the current public health emergency, the consequence of relief not being granted may be that another patient with a neurological condition – who, unlike MB, needs in-patient care – may not be able to receive that care. For every day that MB remains where she currently is, the risk of another patient being affected in that way increases. In addition, as Mr Sinnatt properly emphasised, substantial amounts of the valuable time of the Ward's clinical team, which could be used to attend to patients who require in-patient care, will be taken up caring for MB, who does not require such care. I have no doubt that this court should do whatever it can to prevent those consequences from occurring.

65 For these reasons, I will grant interim relief to enforce MB's discharge from the Hospital.

The terms of the order

66 The Claimant seeks an order (1) requiring MB forthwith to leave the Ward, (2) prohibiting her from trespassing on the Hospital's premises unless readmitted for clinical reasons and (3) prohibiting her from receiving any care or support from the claimant, its servants and/or agents save for assistance with essential personal care and medical care and for the purpose of effecting her discharge and transporting her home. In addition, the Claimant seeks an order (4) that "the claimant is permitted to take all reasonable steps to effect the defendants discharge from hospital and transporting the defendant and her belongings to her home. This discharge will include transferring the defendant from her hospital bed to an ambulance trolley, transport in the ambulance to her home and transferring the defendant from the ambulance trolley onto her bed".

67 I indicated before the hearing that I would require further submissions before making an order in the terms sought at (4). Having canvassed the suggestion with Mr Sinnatt during the course of the hearing on 9 April 2020, he agreed that the proper form of relief at this stage, if I were to decide to grant it, is an order that:

(a) MB must leave the Ward by [a particular time], provided that by that time the Hospital has made arrangements to facilitate the transfer of MB (by ambulance trolley and ambulance) and her belongings from the Ward to the accommodation to which she is to be discharged;

(b) if such arrangements are made, MB must not obstruct or impede their implementation;

(c) MB may thereafter not re-enter the Hospital's premises without the prior written permission of the Claimant, save if admitted by ambulance.

68 I have considered carefully Mr Holland's submission that I should not grant such an order in circumstances where, because of her disability, MB may not consent to being moved while her concerns have not been addressed to her satisfaction. The fact that a defendant may not comply with an order is not, in general, a good reason not to grant it. I will therefore grant the order in the form I have set out. If MB does not comply, she will be in contempt of court and the full range of the court's coercive powers will be available to enforce it.

69 Finally, there remains the question of the time by which MB should be required to leave. Mr Holland submitted that, if an order were to be made, 7 days should be allowed. That would defeat the point of this urgent application, which is to secure this bed at the time when it is needed most by other patients. I will therefore fix the time by which MB must leave the ward as 12 noon tomorrow, Friday 10 April 2020 (or such later time as the Claimant may in writing specify) in case any application is made to the Court of Appeal to stay this order.