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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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KING'S BENCH DIVISION
(JUDICIAL REVIEW)

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IN THE MATTER OF AN APPLICATION BY JR349 (COMMUNITY RESETTLEMENT OF A PATIENT) FOR LEAVE TO APPLY FOR JUDICIAL REVIEW

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Sinead Kyle (instructed by Phoenix Law Solicitors) for the Applicant
Matthew Corkey (instructed by Directorate of Legal Services) for the Belfast Health and Social Care Trust and Southern Health and Social Care Trust
Leah Treanor (instructed by Departmental Solicitor's Office) for the Department of Justice
Ciaran Whyte (instructed by BSO) for the Regulation and Quality Improvement Authority
Ashleigh Jones (instructed by Departmental Solicitor's Office) for the Department of Health, Notice Party

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McLAUGHLIN J

Introduction

[1] This is an application for leave to apply for judicial review and for interim relief in relation to a series of linked decisions by the Belfast Health and Social Care Trust ("the Trust"), Southern Health and Social Care Trust ("SHSCT"), Department of Justice ("the Department") and the Regulation and Quality Improvement Authority ("RQIA") arising out of the programme of community resettlement of patients at Muckamore Abbey Hospital ("MAH"). The application was listed for an urgent out of hours hearing on Friday 12 June 2026 as a result of events over the course of the previous two days during which the applicant learned of Trust plans for his forcible removal from MAH on foot of a detention warrant issued by the Department pursuant to Articles 48(3) and 78(4) of the Mental Health (Northern Ireland) Order 1986 ("the 1986 Order"), authorising his removal to Knockbracken Hospital. As matters transpired, the removal could not be effected on 12 June and the hearing was adjourned until Monday 15 June 2026. The Trust is a proposed respondent on the ground that it is responsible for the applicant's current care within MAH. The SHSCT is a proposed respondent on the ground that it will

be responsible for his care in the community, if he is resettled. In order to facilitate the hearing and determination of the case, the Trust gave an interim undertaking that no steps would be taken to remove the applicant until 12:00 hrs on Tuesday 16 June 2026. A summary of the court's reasons was provided orally in court on the morning of 16 June 2026 and these written reasons have followed.

[2] The applicant seeks interim relief pending a full hearing of the application restraining the Trust and Department from executing the warrant for his detention. The applicant also seeks permanent injunctive relief compelling the Trust to maintain his accommodation at MAH, pending implementation of a suitable agreed permanent community placement.

[3] In light of the urgency with which the application has come on for hearing, it has not been possible for the parties to file evidence in the detail which might normally occur. The Trust has provided a bundle of materials relating to the applicant's original detention and the formal decision of the Department to issue a warrant for the applicant's detention. These have been admitted in evidence, without objection. The Trust also submitted a position paper which contains some additional factual information about the applicant's background and history in MAH, which was more contentious and which I was urged to treat with caution. As set out below, I have not found it necessary to rely upon the contents of the position paper in order to determine this case.

[4] I wish to commend the legal representatives for all of the parties involved in the proceedings for the speed and thoroughness with which they have prepared submissions and gathered materials. I am grateful to all of the parties for their submissions which have been of great assistance.

Background

[5] The applicant is a patient in MAH and has resided there since the mid-1980s. He is currently the last remaining patient in MAH, with all other patients having been resettled successfully with community placements. The applicant has been granted anonymity in these proceedings and the background to his detention is summarised only, in order to avoid the risk of identification.

[6] In the mid-1980s, the applicant was convicted of the manslaughter of a child. The circumstances of the offending included sexual motivation. Upon conviction, he was the subject of a Hospital Order made under Article 44 of the 1986 Order, together with an indefinite Restriction Order, made under Article 47 of the 1986 Order. The applicant was committed to be detained in MAH and he has resided there continuously since that time. His case has been considered by the Mental Health Review Tribunal ("the Tribunal") since his original committal to hospital. In 2013, the Tribunal decided that the applicant's mental impairment was such that he continued to satisfy the first limb of the statutory test for detention in a hospital for

treatment (Article 77(1)(a), 1986 Order). However, it also held that, although his discharge would create a risk of serious physical harm to himself or others, after 28 years living in MAH, the degree of risk was not such as to give rise to a "substantial likelihood" of harm. Accordingly, the second limb of the test for continued detention (Article 77(1)(b)) was not met and he was entitled to be discharged. Pursuant to Article 77(4), the Tribunal considered that it was appropriate for him to continue to be subject to recall to hospital and it set conditions for his discharge. Those conditions included a requirement that he reside "*only at such place or places as may be agreed by his Responsible Medical Officer for the time being.*" The applicant has, therefore, continued to reside in MAH as a discharged patient since that time, on the basis that it has been approved by his Responsible Medical Officer as an appropriate location in which he was able to receive the care and supervision which was necessary to mitigate the risk of harm to others.

[7] As a result of the emergence of allegations of abuse of patients within MAH, the Minister of Health announced the Muckamore Abbey Hospital public inquiry in September 2020, with its formal establishment occurring on 11 October 2021. At that time, MAH was home to many patients suffering from mental impairments such as severe learning difficulties, but who were capable of living in the community with the benefit of supported care packages. The Department then undertook a process of public consultation on the closure of MAH, in accordance with the statutory consultation requirements under the Health and Social Care (Reform) Act (Northern Ireland) 2009. On 6 July 2023, the Department announced that it had decided to close MAH and set a closure date of June 2024. The public statement released by the Department contained the following:

> "This date will be dependent on all remaining Muckamore patients having been appropriately resettled in community settings.
>
> June 2024 date should provide sufficient time for the remaining patients to be discharged into the community. This is an overriding priority, and the Department is working with all Trusts to develop safe discharge arrangements for all patients.
>
> I can give a firm commitment that the closure will be a carefully managed and phased process. A detailed closure plan will be developed, co-produced by patients and families. It will clearly set out how the services currently provided on the Muckamore site will be delivered in an agreed setting."

[8] Since that time various efforts have been made to find a suitable alternative community placement for the applicant where he could reside with the benefit of a

package of support and supervision. Some of the evidence about past efforts to find a community placement proved to be contentious. What is clear is that several efforts have been made in recent years to find an alternative placement and that none have been successful. In a statement prepared by the applicant he acknowledged that he was initially resistant to a move, but he maintains that he has engaged with the resettlement process in more recent times. He stated:

> "13. In the early stages, when closure of MAH had not yet been formally announced, I was reluctant to engage with resettlement. I did not understand why I should leave when other long-stay patients remained. However, once the closure was formally announced following public consultation, my position changed. I accepted the reality of the situation, and I engaged with the process. I even encouraged fellow patients to engage with their own resettlement and to advocate for the best possible outcomes for themselves."

[9] Whatever may have been the cause of difficulties in previous years, the uncontroverted evidence is that within approximately the last year, two separate potential placements were identified by the Trust with the assistance of external organisations and that substantial work was undertaken to progress the placements. These both broke down for various reasons. The applicant appears to have developed concerns about the location, setting and nature of the property involved in the first proposed placement. The second proposed placement appears to have been progressing reasonably positively until recent weeks. While there has again been a suggestion from the Trust that the applicant's interest in the property had waned, he maintains that he remained very positive about the possible transfer and went so far as to purchase new furniture, in anticipation of the move. However, the placement has again proved to be unviable following advice from police. There is a lack of clarity about precisely when the Trust ultimately decided that the placement was not viable.

[10] In February 2026, the RQIA provided the Trust with an Inspection Report following an unannounced inspection of MAH which took place between 1–8 December 2025. The purpose of the inspection was expressed in the following way

> "… to assess and review patient experience and to ensure patients are safe and continue to receive care and treatment that is appropriate to their assessed needs. Given that patient numbers have reduced as part of the resettlement process, it was important to gain a sense of what life is like for the small number of patients who are still living there. The inspection therefore focused on the

> following key themes: environment, staffing, adult safeguarding and patient experience ..."

[11] The RQIA inspection report contained the following conclusion:

> "5.2.6 ... the Trust are committed to maintaining safety, security and stability. However, when patient numbers reduce to a very small number of individuals, the continued operation of a large institutional site become increasingly inefficient and difficult to manage effectively. When only five patients remain on site, the operational model is no longer proportionate to the scale of the environment and does not support safe, high-quality, or person-centered care. This reinforces the need to expedite closure arrangements and implement formal contingency arrangements to transition the remaining patients to more suitable settings."

[12] The RQIA identified two areas where action was required by the Trust to give effect to its findings:

(i) To work with other Trusts and stakeholders to ensure formal contingency plans are in place for all patients.

(ii) When the number of patients remaining in MAH reduced to five, the Trusts and stakeholders must "*ensure that the formal contingency arrangements for those patients <u>are implemented without delay</u>.*" [emphasis added]

[13] Since approximately late May 2026, the applicant has been the last remaining patient residing in MAH. He occupies a single bedroom on a ward with his own bathroom. It is not clear what communications, if any, were ongoing between the RQIA and the Trust about progress with the implementation of the resettlement plans for the last remaining patients. However, it is clear that the RQIA was monitoring events sufficiently closely that it requested and was provided with information about the applicant's position and was therefore made aware that he was the last remaining patient.

[14] On 3 June 2026, the RQIA issued two statutory notices under Article 86(6) of the 1986 Order. One was served on the Trust, the other was served on the Department of Health. Article 86(1) imposes a duty upon the RQIA to keep under review the care and treatment afforded to mental health patients in Northern Ireland. In the exercise of this function, Article 86(2) imposes a duty upon the RQIA to bring to the attention of a range of bodies, including the Department and Trusts, the facts of any case in which it is of the opinion that it is desirable for that body to exercise its functions to secure the welfare of a patient, including *"(ii) remedying any*

deficiency in his care or treatment." Article 86(6) confers a further power upon the RQIA to issue a notice to a regulated entity requiring that it provide information about the steps "*taken or to be taken*" in relation to the matters specified in the notice. It is the duty of the regulated entity "*to comply with the requirements of that notice*."

[15] Both of the Article 86(6) notices record that on 27 May 2026, the RQIA was informed that only the applicant remained living in MAH and that upon further inquiries with the Trust, it learned that his "*planned resettlement to a placement in the community in the [SHSCT] area was no longer a viable option, given the associated risks*." It was also informed by the Trust on 1 June 2026 that "*[the applicant] does not have a defined plan in place for a community placement. The timescales for an alternative community placement are unknown*."

[16] Both Article 86(6) notices also record the following opinion which aligns the views which the RQIA previously expressed in the February 2026 inspection report:

> "The patient's health and well-being are likely to be significantly impacted by their prolonged residence in a large institutional hospital setting, where they have lived for many years and are now the sole remaining individual. This situation raises serious concerns regarding social isolation, quality of life, and the absence of a therapeutic environment aligned with modern standards of care for individuals with a learning disability. The lack of a clear and implemented discharge or resettlement plan represents a substantial deficiency in care and treatment … The continued operation of the hospital for a single individual is neither proportionate nor conducive to person-centred care …"

[17] The notice issued to the Department required that it take urgent action to close the hospital. It states:

> "… The current environment presents significant risks to the patient's welfare, and the facility cannot be considered a suitable or effective setting for ongoing inpatient mental health care.
>
> In light of these concerns, I am formally requesting that the department exercise its authority under Article 86 <u>to urgently review and take steps to close the hospital</u>. This action is necessary to ensure that the patient's rights, safety and therapeutic needs are upheld in accordance with statutory obligations and best practice standards.

> Given the level of risk identified, I must emphasise the urgency of this matter. Delay in addressing these concerns may result in further deterioration of the patient's condition and/or compromise their safety." [emphasis added]

[18] The notice issued to the Trust required the removal of the applicant from MAH. It stated:

> "In order to remedy the current deficiency in this patient's care and treatment, a plan must urgently be put in place, a plan to transfer [JR349] to an alternative hospital placement. The transfer should take place on or before 12 June 2026." [emphasis added]

[19] On 9 June 2026, the applicant's Responsible Medical Officer, Dr Paul Devine, Consultant Forensic Psychiatrist, prepared an updated report on the applicant's condition. He confirmed that the applicant suffers from a "*severe mental impairment of intelligence and social functioning, associated with abnormally aggressive or seriously irresponsible conduct on his part*." It is an enduring developmental disorder which has not materially changed since the index offending and is not expected to change. On the first limb of the statutory test for detention, his opinion was that "*the [applicant] continues to suffer from mental disorder of a nature and degree which warrants detention in a hospital for medical treatment*." He observed that this is not inconsistent with the 2013 decision of the Tribunal. Rather it reflects the fact that the applicant "*continues to require the same level of structured therapeutic intervention and supervision that has been provided throughout the period since conditional discharge*." The treatment which he requires extends beyond conventional medical and nursing care and includes "*provision of a structured environment, specialist multidisciplinary oversight, psychological intervention, social supervision and ongoing psychiatric review*" together with supervision by two staff throughout the day and night. In relation to the second limb of the statutory test for detention, Dr Devine's opinion was that "*his disorder remains the substrate of his risk*." Without the present level of supervision and control, "*the likelihood of serious physical harm to others would be substantial*."

[20] Dr Devine's opinion was clearly provided with knowledge that the possibility of the applicant's recall to a hospital was under consideration. He observed that MAH has provided the necessary structured environment in which the applicant has been able to reside since 2013, but that this may no longer be available. He made the comment "*the RQIA has directed that the current hospital must close on 12 June 2026*" and that this represents a material change in circumstances. Dr Devine also made clear that he attributed no blame to the applicant about the difficulties which have occurred with the resettlement process as he considered that his capacity to engage in the process was substantially affected by his underlying disorder. As set out below, the applicant contends that this report was founded upon a misdirection and

misunderstanding, on the basis that the RQIA has not directed closure of the hospital by 12 June 2026, rather it had requested the preparation of a plan for the applicant's relocation to another hospital by 12 June 2026.

[21] Dr Devine's report was forwarded to the Department in his capacity as Responsible Medical Officer for the applicant. On 11 June, the Department wrote to Dr Devine enclosing a warrant pursuant to Article 48(3) of the 1986 Order, authorising the applicant's recall to Clare Ward, Knockbracken Healthcare Park. It also included a letter addressed to the applicant explaining the decision it had taken and requested that Dr Devine provide the letter to the applicant. The letter states that the decision was based upon the opinion of Dr Devine. It confirmed, inter alia, that the applicant continues to require a highly structured therapeutic environment comprising specialist multidisciplinary treatment, supervision and behavioural management. It states:

> "with the closure of Muckamore Abbey Hospital on 12 June 2026, the DOJ and the RMO are agreed that the specific package of care and treatment which is required to manage the risk of harm to you or the public cannot currently be provided in a community setting … [the nature and degree of your mental illness] warrants your recall to hospital for medical treatment and that a failure to recall at this time would create a real possibility of very serious or life threatening harm."

[22] The applicant's evidence is that he discovered plans for his relocation from MAH, via his solicitor on Thursday 11 June 2026 and that she learned of developments from the SHSCT, after she contacted it to enquire about progress with the community placement which she understood was still an available option. These proceedings were then commenced in circumstances of urgency to stop the relocation process. Pre-action responses from both the Department and the Trust were sent on Friday 12 June 2026 and provided the applicant with more information about what had occurred. However, some of the facts and materials set out above only became available in the course of the proceedings.

Grounds of Challenge

[23] The applicant seeks leave to challenge three related decisions:

(i) The decision of the Department to issue a warrant recalling the applicant to a hospital;

(ii) The decision of the Trust to relocate the applicant from MAH, prior to the identification and implementation of an agreed plan for community resettlement; and

(iii) The Article 86(6) notice issued by the RQIA to the Trust requiring it to provide a plan for relocation of the applicant to another hospital by 12 June 2026.

[24] The applicant also seeks interim relief pending a full hearing, prohibiting the Trust from executing the warrant of detention and removing the applicant from MAH, other than by means of an agreed community resettlement placement.

[25] As appears clear from the summary of the facts set out above, the decisions are all inter-related and are not easily separated, even if they are made by different authorities. The decision to issue the warrant is premised on MAH not being available as a home for the applicant after 12 June 2026. The reason for MAH not being available are the Article 86(6) notices issued by the RQIA requesting the Department of Health to take urgent steps to close MAH and the Trust to relocate the applicant to another hospital by 12 June 2026. Removal of the applicant on foot of the warrant amounts to the implementation by the Trust of the contingency plan which the RQIA required the Trust to put in place.

[26] The proposed grounds of challenge are:

(i) Legitimate expectation;

(ii) Articles 3, 5, 8 and 14 ECHR;

(iii) Irrationality/procedural fairness; and

(iv) Breach of section 2 of the Health and Social Care (Reform) (NI) Act 2009 and Article 15 of the Health and Personal Social Services (NI) Order 1972.

Legitimate Expectation

[27] The applicant does not dispute that the Department of Health has a power to close MAH, nor does he challenge the decision to do so, which was announced in July 2023, following public consultation. Indeed, the applicant does not challenge the actions of the Department of Health at all. It was a notice party only to the proceedings. The applicant does not challenge the RQIA's Article 86(6) notice requiring the Department of Health to take urgent steps to close MAH. Similarly, the applicant does not challenge the fact that the applicant is subject to an indefinite restriction order made under Article 47 of the 1986 Order and that he is liable to be recalled to hospital for treatment at any time. The challenge is directed at the actions by the Department, the Trust and the RQIA to take steps to remove the applicant, prior to an agreed community resettlement placement, contrary to commitments to that effect.

[28] The applicant relies upon a series of statements and commitments by the Department of Health, regarding the timing of closure.

[29] On 6 July 2023, when announcing the decision to close MAH by June 2024, the Department of Health gave the following public commitment:

> "This date will be dependent on all remaining Muckamore patients having been appropriately resettled in community settings."

[30] In May 2024, the applicant's solicitor wrote to the Department of Health about the forthcoming date for closure. In a response dated 28 May 2024 from the Departmental Solicitor, it was stated:

> "Your correspondence alleges a failure to confirm that all the patients remaining in [MAH] will benefit from being provided with appropriate alternative placements before the hospital is closed, and that this appears to amount to a change of position. The department strongly refutes this, for the reasons set out below …
>
> … The oversight board is aware that [the applicant's] placing Trust has made every reasonable effort to engage with him and his relatives on potentially suitable options for his resettlement and will continue to do so until such time as [the applicant] has being successfully resettled. This planning does however require the full engagement of all parties to ensure a successful resettlement plan can proceed … The oversight board's most recent assessment is that not all the remaining patients, including [the applicant] will be successfully resettled in advance of the proposed closure date in June.
>
> It is recognised that introducing a second step into their resettlement process may be detrimental to patients' well-being and could heighten anxiety levels and risk undermining the work being done to prepare for their resettlement. Consequently, all those involved in the planning and delivery of resettlement are committed to doing their best to ensure that no patient would need to be moved twice … As patient numbers reduce, the focus is on ensuring the services at the hospital can continue to be provided safely and it will be important to make sure that any contingency arrangements that may be necessary to facilitate this are in place. The primary purpose of any

> such arrangements will be to ensure the safety and well-being of the remaining patients."

[31] On 5 June 2024, the SHSCT acknowledged that the prospect of closure was causing distress and anxiety to the applicant, and it stated:

> "The SHSCT and [the Trust] are committed to working with [the applicant] to identify a community placement however, to date, this has been difficult due to [the applicant's] reluctance to engage in discharge planning processes."

[32] On 12 June 2024, the Trust also acknowledged the distress and anxiety experienced by the applicant at the prospect of closure and stated:

> "The target date for closure of June 2024 is contingent on the successful resettlement of all remaining patients to appropriate community placements. Belfast Trust staff will continue to offer daily care, support and reassurance whilst resettlement plans are developed and finalised. In your client's case, this work will be undertaken collaboratively with our colleagues in [SHSCT].
>
> It is highly unlikely that any of these options will be finalised before the end of June 2024. [The applicant] (and a small group of other patients) will therefore remain on the hospital site beyond this date. It is important for me to emphasise, however, that this, in itself, does not indicate that the hospital is to remain open indefinitely, it is simply an extension of the closure plan. It is similarly important for me to emphasise the importance of future engagement with the resettlement process."

[33] It is trite law that a commitment or assurance by a public authority about the manner in which it will exercise a discretionary power will only be capable of supporting an enforceable legitimate expectation where the content of the assurance is clear, unambiguous and devoid of relevant qualification. The relevant commitment must be read in context. Where it emerges from a series of communications, it is also necessary to examine the chain of communications as a whole to ascertain its true content and meaning. Where an assurance of the requisite quality is made, the onus will then shift to the relevant public authority to adduce evidence to justify any departure (*Paponette v AG* [2011] 3 WLR 219). It then falls to the court to assess the justification put forward and to make an assessment of whether or not a failure to enforce the promise would be impermissibly unfair to the

applicant. In *Re Finucane* [2019] UKSC 7, the Supreme Court expressed the test in the following terms:

> "[62] From these authorities it can be deduced that where a clear and unambiguous undertaking has been made, the authority giving the undertaking will not be allowed to depart from it unless it is shown that it is fair to do so. The court is the arbiter of fairness in this context. And a matter sounding on the question of fairness is whether the alteration in policy frustrates any reliance which the person or group has placed on it. This is quite different, in my opinion, from saying that it is a prerequisite of a substantive legitimate expectation claim that the person relying on it must show that he or she has suffered a detriment."

[34] Considering the entire series of communications and commitments given by the Department or the Trust over the period since 2023, my assessment is that the early promises that MAH would not be closed until such time as all of the patients had been resettled, probably are sufficiently clear and unambiguous in their content to generate a legitimate expectation. However, when read alongside the communications which came in later years, it seems to me to be clear that those commitments became less unequivocal and contained relevant qualifications. As the original deadline for closure approached and it became clear that the resettlement process would be longer and more complex than expected, the Trust's statements adapted to those circumstances. In particular, in May 2024, it was emphasised that it would be necessary for the Trust to develop safety focused "*contingency arrangements*." Rather than a clear commitment to patients remaining until resettled, it was stated that staff were committed to "*doing their best*" to avoid the need for a two-stage resettlement process. The refence to a two-stage process and to "*contingency arrangements*" cannot be a reference to anything other than a qualification of the commitment to direct resettlement of all patients. In my view, the existence of a qualification of this nature within the commitment is made even more expressly clear by the 12 June 2024 correspondence which expressly informed the applicant that, in light of the difficulties which had been experienced in finding a suitable placement, he should <u>not</u> understand the commitment around closure to mean that MAH would remain open "*indefinitely*."

[35] Viewing all of these communications collectively, my assessment is that they do not amount to a clear and unambiguous commitment which is devoid of relevant qualification that the applicant could remain in MAH until an agreed community placement had been implemented. I consider that, viewed in context, they contain an implicit qualification that the arrangements for resettlement would always be subject to an overriding obligation upon the Trust to ensure the provision of safe care within the hospital and that the resettlement of some individual patients may be

required to yield to that overriding obligation, where resettlement could not be achieved compatibly with the requirements of safe care. In addition, I consider that any expectation that the applicant could stay until he agreed to a community placement, could not be a legitimate one, since it potentially gives him the final say on closure. Such a position would be contrary to the statutory scheme, which confers the power of closure exclusively upon the Department, following consultation. The commitment contended for could, in theory at least, result in MAH remaining open indefinitely, while the applicant remains alive. In my view, the express qualifications to this effect communicated by the Trust are simply a reflection of qualifications which were always implicit. Accordingly, I do not consider that the assurances and commitments relied upon by the applicant achieve the requisite legal standard to support the existence of an enforceable expectation.

[36] In the alternative, if I am incorrect in the above analysis, it is clear that the communications in May and June of 2024 themselves represented a departure from the initial commitment, which has now been implemented through the impugned decisions of the Trust, DOJ and RQIA. In those circumstances, the issue then becomes one of justification. In most cases, the evidential onus upon a proposed respondent would require evidence from the decision maker. However, in this case, the court does have evidence of the rationale for and the circumstances of the impugned decisions. It may be that, if leave was granted, the Trust or Department may be able to file further evidence to explain and justify the decisions. However, even on the basis of the information which is available to the court at this stage, it is clear to me that the current decisions do not represent a sufficiently unfair departure from a commitment that the applicant could remain in MAH until an agreed resettlement placement was implemented. I consider the following evidence to be of particular importance:

(i) MAH is a hospital and the applicant currently resides there under the care of the Trust. The primary duty of the Trust is to ensure that he is safe and that appropriate care is delivered to him. He resides in this environment on foot of an indefinite restriction order, made following his conviction for manslaughter and he has always been subject to the possibility of recall to detention in hospital, notwithstanding his discharge in 2013.

(ii) The decision to close MAH was made in 2023 by the Department, following a public consultation process. It is therefore a firm and lawful policy objective for the Department, which has been widely known since that time by the public, staff and patients alike.

(iii) The Trust has clearly not departed from its commitment to find a suitable community placement for the applicant. On the contrary, it remains committed to that course of action and it has made extensive efforts to do so, albeit that those placements have been unsuccessful to date, for a range of reasons. There are no current placements under consideration and there is no

timescale for identifying an alternative. The prospect of a prolonged continued residence in MAH is a real one.

(iv) The Trust has been successful in achieving community placements for all other patients. To that extent it has had a very high level of success in fulfilling the commitments which were made to all patients.

(v) The applicant is now the only patient left and MAH no longer operates as a hospital.

(vi) The independent statutory authority responsible for regulating the provision of care in MAH has concluded on a clear and reasoned basis that it is no longer safe for the applicant to remain in MAH. Since it no longer functions as a hospital, it can no longer deliver the care and treatment which he requires and which are necessary to manage the risks which he poses. Not only has it formed this view after a detailed inspection of the premises several months ago, it has now gone so far as to exercise its statutory powers to require the Department to close MAH and to require the Trust to implement its contingency plan to relocate the applicant by 12 June 2026. In the words of the Article 86 notices, it considers that there is currently a deficiency in the care and treatment being provided to the applicant and also that the actions identified in the notices are necessary to remedy that deficiency.

[37] In addition to the above evidence, the Trust provided unsworn information about the costs associated with maintaining the MAH on a weekly and monthly basis. I do not find it necessary to give weight to this information as the court is well placed to take judicial notice of the fact that there are likely to be costs, staffing and security complications arising from maintaining MAH open in circumstances where the applicant is the only resident.

[38] For all of the above reasons, I consider that, even if the impugned decisions do amount to a departure from a promise that the applicant could remain in MAH until an agreed community placement was implemented, it is clear that the impugned decisions are justified on the basis of the information which is currently available to the court. Balancing the respective public and private interests, there is a clear public interest in ensuring the continued safe delivery of medical care and treatment to the applicant, both for his own safety and that of the public. There is also a public interest in the implementation of a lawful and unchallenged decision of the Department to close MAH, which was made following public consultation. The court has the benefit of the independent expert views of the RQIA regarding the existence of deficiencies in the applicant's current care and the steps which it considers to be necessary to remedy those deficiencies, including the urgent closure of MAH and relocation of the applicant. The applicant has an undoubted private interest in remaining in MAH, which has been his home for approximately 40 years. It cannot be doubted that his removal from that setting is likely to have a significant

personal effect upon him, at the very least in the form of distress and anxiety. However, MAH is no longer the setting or environment to which the applicant was originally committed and in which he has remained. This change is the natural consequence of the Department fulfilling the commitment which it made to resettle patients in the community. Balancing all of these factors, I do not consider that the consequences of the impugned decisions to be so unfair as to require enforcement of a commitment for the applicant to remain at MAH until such time as a community resettlement place has been agreed with him and implemented. Accordingly, I do not consider that this ground of challenge is arguable or that it has a realistic prospect of success.

Articles 3, 5, 8 and 14 ECHR

[39] The primary argument advanced by the applicant was that implementation of the warrant and his forceable removal from MAH would give rise to a breach of his rights under article 5 ECHR.

[40] Article 5 provides in relevant part as follows:

> "5(1) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> (a) the lawful detention of a person after conviction by a competent court ...
>
> (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants."

[41] Since the legal basis for the applicant's proposed recall to detention is the restriction order made following his conviction, the legality of that detention falls to be examined under article 5(1)(a) and (1)(e). A breach of article 5 will not therefore arise unless the detention falls foul of the convention requirement for legality and of the domestic statutory provisions governing the detention of a person suffering from mental illness. The leading Strasbourg authority on the detention of patients is *Winterwerp v Netherlands* (1979) 2 EHRR 387. It established the following core principles for determining whether such a detention meets the requirements of legality:

> "39. The next issue to be examined is the "lawfulness" of the detention for the purposes of article 5(1)(e). Such "lawfulness" presupposes conformity with the domestic

> law in the first place and also, as confirmed by article 18, conformity with the purpose of the restrictions permitted by article 5(1)(e); it is required in respect of both the ordering and the execution of the measures involving deprivation of liberty (see the above-mentioned *Engel and others* judgment, p. 28, para. 68 in fine).
>
> As regards the conformity with the domestic law, the court points out that the term "lawful" covers procedural as well as substantive rules. There thus exists a certain overlapping between this term and the general requirement stated at the beginning of article 5(1), namely observance of "a procedure prescribed by law" (see para. 45 below).
> …
>
> The court fully agrees with this line of reasoning. In the court's opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of "unsound mind." The very nature of what has to be established before the competent national authority – that is, a true mental disorder – calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder (see, mutatis mutandis, the *Stögmüller* judgment of 10 November 1969, Series A no. 9, pp. 39-40, para. 4, and the above-mentioned *De Wilde, Ooms and Versyp* judgment, p. 43, para. 82)."
> [emphasis added]

[42] Pursuant to Article 78(4) of the 1986 Order, a person who is subject to a restriction order and who has been conditionally discharged, may be recalled in accordance with Article 48(3). It confers an unconditional power of recall upon the Department (formerly the Secretary of State), in the following terms:

> "48(3) The Secretary of State may at any time during the continuance in force of a restriction order in respect of a patient who has been conditionally discharged under paragraph (2) by warrant recall the patient to such hospital as may be specified in the warrant …"

[43] This power is in materially similar terms to that which applies in England & Wales and its exercise has been the subject of judicial consideration on a number of

occasions. The relevant authorities are summarised in the decision of Burnett J in *R(Munday) v SOSHD* [2009] EWHC 3638 where he applied the test laid down in *R(MM) v Secretary of State for the Home Department* [2007] EWCA 687 Civ:

> "28. 'For the Home Secretary to recall a patient who has been conditionally discharged by a MHRT, he has to believe on reasonable grounds that something has happened, or information has emerged, of sufficient significance to justify recalling the patient. As I have said, it is not in dispute that he must have up-to-date medical evidence about the patient's mental health. Since in the nature of things the patient will have a RMO, it is hard to imagine that (save in the most exceptional circumstances) the Home Secretary would recall the patient without first seeking the RMO's clinical opinion whether it is appropriate for the patient to be detained for treatment. But I do not think that it would be appropriate for this court to lay down some form of test of general application extrapolated from the particular circumstances of this case'.
>
> … the Home Secretary should ask himself whether there had been such a material change of circumstances since the Tribunal's previous decision that he could reasonably form the view that the detention criteria were now satisfied."

[44] It was also made clear in *MM*, that a recall decision was subject to a rationality challenge only.

[45] In this case, there are two aspects to the challenge:

(i) The adequacy of the opinion of Dr Devine as a foundation for the recall decision.

(ii) Whether the decision was irrational on the ground that Dr Devine had a misunderstanding of the facts or otherwise took into account an irrelevant consideration insofar as his opinion was premised upon his belief that the RQIA had decided to close MAH by 12 June 2026.

[46] I consider that the first limb of the challenge plainly fails to meet the threshold for the grant of leave. The opinion of Dr Devine is clear and unequivocal that the applicant continues to meet both limbs of the statutory test for detention in a hospital for the purposes of treatment. There was no contrary evidence and there was no real

dispute that his opinion was an entirely rational and proper one, in light of the applicant's history and the prior decisions of the Tribunal.

[47] As regards the second limb of the challenge, the source of Dr Devine's understanding that the RQIA had decided that MAH must close by 12 June 2026 is not entirely clear. On a strict reading of the two Article 86(6) notices, it is clear that the RQIA did not make a request in those precise terms either to the Trust or to the Department. However, stepping back and looking at both notices together, the RQIA did require that the Department take urgent steps to close MAH and did require that the Trust prepare a plan to transfer the applicant to another hospital by 12 June 2026. On a fair and objective reading of the notices, it is clear that the RQIA did make decisions whose effect was that the necessary supportive surroundings previously available to the applicant should no longer be available after 12 June 2026. It cannot therefore be said that Dr Devine was labouring under a material misunderstanding of the facts, had left material considerations out of account or had misdirected himself to such an extent as to undermine the validity of his opinion. In my view, his opinion reflects the reality of the current situation and the outworkings of the steps which the RQIA has required both the Trust and Department to take. In those circumstances, I do not consider that there is any arguable breach of the domestic law obligations upon the Department when making the recall decision.

[48] Similarly, I do not consider that there is any additional arguable breach of the *Winterwerp* requirements for an article 5 ECHR compliant detention. As made clear by Dr Devine, the applicant is clearly suffering from a mental disorder of sufficient severity to justify detention in a hospital for treatment. The duration of that detention will be dependent upon both its continuance and the suitability of the environment for his discharge. Once detained, his case must be referred to the Tribunal for review (Article 80, 1986 Order). I was informed by counsel that it is the intention of the Department to make such a referral promptly and that a separate referral had already been made by the Department under Article 76(1) of the 1986 Order on 20 May 2026, independently of the decision to recall the applicant.

[49] For all of the above reasons and applying a strict scrutiny of the facts, I do not consider that the impugned decisions give rise to an arguable breach of article 5 with reasonable prospects of success.

[50] The applicant also contended that the decisions would give rise to a freestanding breach of article 3 ECHR on the ground that it was inhuman and degrading treatment to remove the applicant from MAH in these circumstances. I do not consider that it is arguable that the applicant has been subjected to degrading treatment or that any aspect of the treatment he has received from any of the relevant authorities could be regarded as contrary to human dignity. While it is clear that the applicant will suffer distress and anxiety as a result of an enforced move from MAH to a psychiatric hospital before a community placement has been identified and

agreed, I do not accept that this could come close to the minimum level of severity which would be necessary to give rise to an arguable form of inhuman treatment.

[51] The applicant did not press in argument the pleaded challenges based upon articles 8 or 14 ECHR and I have not analysed them further. However, it is clear from the above analysis that even if an interference with article 8 could be established, it is clearly justified under article 8(2) for the same reasons.

[52] None of the Convention arguments therefore give rise to an arguable ground of challenge which has reasonable prospects of success.

[53] Some argument was devoted to whether or not the Tribunal referral amounted to an adequate alternative remedy, which might justify the refusal of leave. While I consider that it could be an appropriate forum to challenge the merits of Dr Devine's opinion, it is unlikely to be capable of providing the relief which is sought in these proceedings. However, in light of the view which I have reached about the merits of the proposed challenge, it is not necessary to consider this issue further.

Irrationality/procedural fairness

[54] For the same reasons as are set out above in relation to the article 5 challenge, I do not consider that the impugned decisions are arguably vitiated by irrationality. There is no sustainable argument that Dr Devine's opinion on the applicant's mental illness or the need for treatment in a hospital is flawed and it is not founded upon a material misunderstanding of the facts surrounding the role of the RQIA or the pending closure of MAH.

[55] The applicant was unable to identify any specific procedural safeguard which ought to have been afforded to him and which was omitted, save to complain about the abruptness with which news of his possible enforced removal was communicated to him. The appropriate procedure for challenge to the opinion or views of Dr Devine is through the referral to the Tribunal.

[56] Neither of these proposed grounds of challenge are therefore arguable with reasonable prospects of success.

Section 2 of the Health and Social Care (Reform) Act (NI) 2009 and Article 15 of the Health and Personal Social Services (NI) Order 1972

[57] The applicant also contends that the decision to detain and remove him to Knockbracken would give rise to a failure to deliver the care and treatment for which he has been assessed, in accordance with the statutory duties under the 2009 Act which were considered by McCloskey J in *JR47* [2013] NIQB 7. The assessed need which it is contended has not been and will not be provided is appropriate

community accommodation. The reasons for past failures in the provision of a community placement are varied, including the applicant's past reluctance to engage in the resettlement process and, more recently, due to the advice of PSNI on the suitability of the location, despite considerable efforts by the Trust. There has been no challenge until now to the failure to make that provision immediately available. As explained by Scoffield J in *JR138* [2022] NIQB 46, at [56], even when a Trust has determined the appropriate care to be provided, there is some measure of leeway and discretion as to its actual provision, depending upon the circumstances. In this case, there is no suggestion that, pending a community placement, the applicant has not been in receipt of the care and treatment which he requires or that the same level of care and treatment will not be available to him in Knockbracken. The evidence is that he will be provided with the same care, albeit in a different location. On one view, the content of the RQIA inspection report and Article 86(6) notices may suggest that a breach is more likely to arise if the applicant remains in MAH in its current conditions.

[58] In light of the nature of the relevant statutory duty and the absence of any prior challenge to the failure to provide a community placement, I do not consider it to be arguable that there is likely to be any gap in the provision of the necessary care and treatment to the applicant if he is moved to Knockbracken. Nor is it arguable that the absence of an agreed community placement to date amounts to breach of either statutory duty. The applicant has had over three years to make such a challenge and has not done so. It is undisputed that the Trust has been working on numerous placements over the years, which were unsuccessful and appeared to be on the cusp of success, until very recently. Accordingly, this ground of challenge is not arguable with reasonable prospects of success.

Conclusions

[59] For all of the above reasons, I do not consider that any of the proposed grounds of challenge are arguable, with reasonable prospects of success and I refuse leave on all grounds. In light of that finding, it is not necessary for me to determine the application for interim relief, as the applicant has not satisfied the first requirement for such relief.

[60] After the hearing was concluded and following a request from the court, the applicant confirmed instructions that he may make an alternative legitimate expectation argument to the effect that he had an expectation to more notice before any forceable removal. In light of the findings which I have made above, I do not consider that any such promise has been made with the requisite clarity and in any event, departure from it would be justified in light of the very clear and unequivocal opinion of the RQIA as to the timescale for his relocation. However, it is not clear to me from the evidence why the Trust delayed so long in informing the applicant. The RQIA notices of 3 June 2026 state that it was informed about the unviability of the most recent placement on 27 May 2026. In oral submissions, the Trust stated that it

remained hopeful that the placement may still be viable and that a final decision on non-viability was not taken until 8 June 2026. I did also harbour some concerns during the course of the hearing that the Trust may have delayed in order to minimise the risk of a legal challenge. However, no evidence was available on this issue. It is difficult to make any assessment, and it is ultimately of no significance in light of the conclusions I have reached on the grounds of challenge. The Trust is clearly aware of the applicant's mental condition and of distress and anxiety which he is experiencing. It is for the Trust to determine whether some additional time to adjust and to prepare for relocation is appropriate.

[61] The applications for leave to apply for judicial review and for interim relief are refused.