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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION
(JUDICIAL REVIEW)

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IN THE MATTER OF AN APPLICATION BY JR 148
FOR LEAVE TO APPLY FOR JUDICIAL REVIEW

AND IN THE MATTER OF DECISIONS OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

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Mr Kevin Morgan (instructed by KRW Law Solicitors) for the Applicant
Mr Philip McAteer (instructed by the Director of Legal Services) for the proposed Respondent

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COLTON J

Introduction

[1] I am obliged to counsel for the manner in which they presented and argued this case. Their written and oral submissions were of great assistance to the court.

[2] The applicant is a man in his early 50s who, as a child, experienced multiple incidents of serious sexual abuse by a number of adults, suffering psychiatric injury as a result. He has a long history of very serious mental health illness, including diagnosis of complex post-traumatic stress disorder, personality disorder, emotionally unstable and narcissistic traits and suicidal ideation.

[3] In light of his history and his ongoing serious medical condition the court directed that nothing should be reported that would identify the applicant. He has been provided anonymity for the purposes of these proceedings and is to be referred to as JR 148.

[4] The applicant continues to have complex needs as a mental health patient. His treatment includes the taking of extensive prescription medication for an

extended period and regular admissions to mental health hospitals. Since October 2017 he has been receiving mental health treatment in the community. This includes treatment at his general practitioner, treatment in his home and out-patient services. He also avails of assistance with crisis services, counselling services, occupational therapy and community psychiatric nursing.

[5] It is the view of both the applicant and those treating him that it is in his best interests that he receive care in the community rather than as an in-patient for his complex problems.

[6] The genesis of this application relates to the applicant's dissatisfaction about responses from the relevant Trust to complaints about his treatment.

[7] In particular, he avers that since the beginning of the restrictions imposed by the Covid-19 pandemic he has struggled with the Home Treatment Crisis Response Team ("HTCR"). This service provides intensive home treatment and support to those experiencing severe mental health problems who would otherwise have no option but to be admitted to hospital. Because of the changes to his treatment brought about by the Covid-19 pandemic he has been required to contact the HTCR on a more frequent basis.

[8] More generally he makes the case that he has had to make repeated admissions to a mental health institution as an in-patient because he considers that the treatment he receives through the community does not adequately meet his individual requirements.

[9] The focus of this application is his dissatisfaction with the response he received to complaints he has raised with the Trust.

[10] These issues were raised by him at a meeting with representatives of the Trust on 4 March 2020. His complaints related to dissatisfaction with the input provided by the Support and Recovery Mental Health Services in relation to a referral on 20 January 2020. The applicant's complaints were addressed in a response from the Director of Mental Health and Disability Services in the relevant Trust.

[11] In addressing the issues raised by the applicant the Director confirmed that the representatives the applicant had met on 4 March 2020 reviewed all his referrals to the HTCR in the previous six months. He also undertook to review calls he had made to the service provided by Trasna House which provides support and recovery services to patients such as the applicant. Finally, he addressed a missed appointment and check on progress of an occupational therapy assessment.

[12] In relation to HTCR referrals it was noted that there had been 11 calls to the Out of Hours (OoH) GP Service during the relevant period. With the exception of one call on 20 January 2020 all requests made were responded to by the HTCR team within the Trust's two-hour response target.

[13] The correspondence confirmed that HTCR was unaware of the referral on 20 January 2020. The Trust was unable to explain why the complaint had not reached HTCR. As a result the Director apologised for the distress this incident caused the applicant. He also undertook to communicate to all GPs the importance of raising failed contacts contemporaneously to permit a full investigation.

[14] The Director also referred to subsequent incidents on 10 April 2020 and 22 May 2020 in relation to contact with the HTCR team. The responses on those occasions were in adherence to the Trust's protocols.

[15] In relation to the calls made to the Duty System in Trasna House the Director noted the issues raised by the applicant on delayed return of calls or absence of return of calls.

[16] It was accepted that on reviewing the available records it was evident that the applicant had left messages for staff and calls had not all been returned in a timely manner, nor contact made on each occasion. It was acknowledged that this was not acceptable and fell below the standard expected of the service. Again, an apology was offered. The letter confirmed that the Trust had undertaken a programme of supervision and time management to ensure that this would not continue. Additional resources were also made available for the Duty Rota in Trasna House to help address this issue. Other changes introduced were to be monitored.

[17] In relation to the occupational therapy assessment it was confirmed that a referral had been made but the Trust had been unable to progress new assessments due to the Covid-19 situation and it was hoped that this service could recommence in "*the coming weeks*." In addition, the Director confirmed that the applicant did not receive his seven day follow-up visit as scheduled on his discharge from in-patients. This was attributed to a breakdown in communication between the ward and his key worker.

[18] The Director also addressed two further issues raised by the applicant. The first referred to his complaint that he did not have a seven day follow-up visit as scheduled on his discharge from inpatients which the Director attributed to a breakdown in communication between the ward and his key worker. The second related to a complaint that he had not been provided with an outcome to a previous meeting with mental health staff. The Director attributed this to delay in the typing of the notes of the meeting. These have now been concluded and the notes were available.

[19] On a proper analysis of the applicant's complaint two separate issues arise. The first relates to his belief that his requirement for in-patient treatment could be avoided if the treatment he received in the community was consistent and of the standard to which he feels entitled. He feels the failings about which he complains

pose a significant risk to his health and undermine the efficacy of his treatment in the community.

[20] The second issue, although related to the first, is his belief that there is an inadequate response to the complaints he makes. The remedy to the issues he raised is, in his view, the requirement for the proposed respondent to put in place an independent regime to regulate and inspect mental health provision provided to persons in the community.

The relief sought by the applicant

[21] Accordingly, in this application the applicant challenges:

> *(a) The proposed respondent's failure to adequately arrange for independent inspection of MHS mental health treatment provision to persons in the community, that is, treatment provided or managed by the relevant HSC Trust outside hospital in-patient treatment; or*
>
> *(b) The proposed respondent's failure to adequately regulate NHS mental health treatment provision to persons in the community, that is, treatment provided or managed by the relevant Health and Social Care Trust outside hospital in-patient treatment;*
>
> *(c) The proposed respondent's failure to procure the inspection and regulation of such matters.*

[22] He seeks the following primary relief:

> *(a) A declaration that the respondent's failures referred to above are unlawful on the basis that they breach Articles 2, 3 and 14 of the European Convention of Human Rights.*
>
> *(b) An order of certiorari to bring into this court and quash the determinations in paragraphs (a), (b) and (c) above.*
>
> *(c) A declaration that the proposed respondent has the duty to establish a system of inspection and regulation for NHS mental health treatment provision to persons in the community.*
>
> *(d) An order of mandamus requiring the proposed respondent to reconsider its decision as to inspection and regulation in this context in accordance with the law.*

Further Evidence

[23] The applicant's solicitor, Mr Kevin Winters, has sworn an affidavit exhibiting material in the public domain which relates to this issue. In particular, he draws attention to duties imposed in England in a similar context by section 46 of the Health and Social Care Act 2008. This provision imposes duties on the Care Quality Commission ("CQC") to conduct reviews of the carrying on of regulated activities by service providers, assess the performance of the service providers, publish a report and prepare statements in relation to such issues. The regulated activities and service providers includes community mental health services. There is a similar provision in Wales. He also draws the court's attention to public commentary on the issue of the Regulation of mental health treatment in the community in Northern Ireland from journalists, politicians and the Human Rights Commission.

The focus of the applicant's claim

[24] It is important to understand that this is not a claim based on criticism of the clinical care provided to the applicant. There is no sufficient evidence to substantiate such a case and in any event such a claim would not be suitable for review by this court. An allegation of inadequate clinical care would best be pursued by way of a civil claim. Further, as will be discussed below, it is not the proposed respondent but rather the relevant Trust which is responsible for the actual provision of care to the applicant.

[25] The focus of this claim relates to an alleged failure on behalf of the proposed respondent in the macro policy area concerning the arrangements for the regulation and inspection of community mental health services.

[26] In assessing the applicant's case it is important to understand the structure by which mental health treatment provision to persons in the community is provided to patients such as the applicant.

The basic structure for the provision of health care in Northern Ireland

[27] The key statutory provision is the Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the 2009 Act").

[28] Under section 2(1) of the 2009 Act, the Department has a general target duty relating to the health care system in Northern Ireland. Specifically, under section 2(3)(d)-(j) the Department is obliged to:

> *"(d) set standards for the provision of health and social care;*
> …
> *(f) formulate the general policy and principles by reference to which particular functions are to be exercised;*

(g) secure the commissioning and development of programmes and initiatives conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland;

(h) monitor and hold to account the Regional Board, the Regional Agency, RBSO and HSC trusts in the discharge of their functions;

(i) make and maintain effective arrangements to secure the monitoring and holding to account of the other health and social care bodies in the discharge of their functions;

(j) facilitate the discharge by bodies to which Article 67 of the Order of 1972 applies of the duty to co-operate with one another for the purposes mentioned in that Article."

[29] The Department funds the Health and Social Care Board and Health Care Services more generally; section 2(3)(c) and paragraph 16 of Schedule 1 to the 2009 Act. Under this Act the Department has powers to direct and give instructions to the Health and Social Care Board for the commissioning of health care in Northern Ireland. The Department also has overall powers to declare the Health and Social Care Board to be in default of its duties and functions, and, ultimately, discharge those functions itself.

[30] The Health and Social Care Board was established under section 7 of the 2009 Act. The Board is responsible for:

(a) Establishing and maintaining effective systems for commissioning health care;

(b) Publishing an annual document setting out the health care it will commission that year;

(c) Commissioning health care and securing the delivery of that care to meet assessed needs.

[31] Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 establishes the Health and Social Care Trust ("HSCT"). These are the main providers of health care services to the public. These services are provided in response to the HSC Board's Annual Commissioning Plan.

What are the current arrangements for the regulation and inspection of community mental health services?

[32] Even though this matter was heard by way of a leave application the court did receive significant material in relation to existing mechanisms of regulation and review of such services.

[33] In this regard the role of the Regulation Quality Improvement Authority ("RQIA") is important.

Mental Health (Northern Ireland) Order 1986

[34] In addition to the statutory provisions in the 2009 Act the Mental Health (Northern Ireland) Order 1986 ("the 1986 Order") makes general provision for mental health treatment, including compulsory treatment, admission and detention in hospital, criminal justice provisions, registration of private mental health hospitals, High Court powers, duties and functions and other aspects of mental health care and treatment.

[35] The scope of the 1986 Order is wide. The definition of "patient" in Article 2 provides that a "patient (except in Part VIII) means a person suffering or appearing to be suffering from mental disorder."

[36] Part VI (Articles 85-89) of the 1986 Order confers duties and powers on the RQIA. This includes a provision in Article 86(1) that provides:

> "It shall be the duty of RQIA to keep under review the care and treatment of patients, including (without prejudice to the generality of the foregoing) the exercise of the powers and the discharge of the duties conferred or imposed by this Order."

[37] When originally enacted Part VI conferred duties on the Mental Health Commission but section 25 of the 2009 Act transferred these functions to the RQIA.

[38] In preparation for the transfer the RQIA in 2008 conducted a due diligence review of the Commission, in which it noted the functions of the Commission as follows:

> *"The Mental Health Commission for Northern Ireland keeps under review the care and treatment of citizens who experience mental ill-health and those with a learning disability.*
>
> *The Commission was established under [the 1986 Order], to protect the interests of persons with mental health and learning disability needs.*

It visits citizens and/or their relatives in hospital and community environments, and people with a learning disability who live in hospital, nursing or residential homes, or with their families.

The Commission monitors the use of compulsion, and it will investigate complaints that powers have been misused. However, it cannot release people from compulsion under [the 1986 Order]. This function is performed by a different body; the Mental Health Review Tribunal.

The Commission has a legal duty to inquire into any person's situation if it appears to it that there may be:

- *Ill-treatment;*
- *Deficiency in care or treatment;*
- *Improper detention in hospital;*
- *Improper reception into guardianship; or*
- *Exposure to loss or damage of a patient's property by reason of their mental disorder."*

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

[39] The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 ("the 2003 Order") constitutes the Regulation and Quality Improvement Authority ("RQIA") and provides the general duties and responsibilities of the organisation. The 2003 Order does not provide specific duties in respect of mental health services.

[40] Community Mental Health Services are commissioned by each of the five Health and Social Care Trusts. RQIA does not have the same regulatory powers with regard to inspection and monitoring of HSC Trusts as it does in respect of establishment and agencies as described under Part III of the 2003 Order such as adult placement facilities, day care centres, domiciliary care services and independent hospitals.

[41] The general functions of RQIA in relation to both those establishments and agencies which are required to be registered with it and those health and social care services for which statutory bodies have responsibility are set out in Article 35 of the 2003 Order.

[42] Included in these functions is the ability of RQIA to investigate either the management, provision or quality of the health and social care service which an HSC Trust is responsible for (as noted above, in general, Health and Social Care Trusts are

responsible for the quality of care they provide or commission) which could include provision of mental health services in the community. RQIA has the power, in accordance with Article 38 of the 2003 Order, to issue improvement notices on a particular HSC Trust or the Health and Social Care Board where failings in minimum standards with regard to the provision of a service has been found; or can report its view or findings to the Department and include recommendations for improvement of the service.

[43] The Department of Health, at any time, can also request the RQIA to conduct a review, investigation or inspection of services provided by or commissioned by Health and Social Care Trusts, including mental health services provided in the community. Reviews can also be carried out in line with its own review programme, which again can relate to mental health services provided within the community. Outcomes of such reviews are made available and reported to all relevant bodies and can include recommendations for improvement.

[44] In written submissions Mr McAteer on behalf of the proposed respondent provided a number of examples of RQIA reviews into mental health services. These included:

(a) Review into emergency mental health services [2019];

(b) Review into perinatal mental health services [2017];

(c) Review of Eating Disorder Services [2015];

(d) Review of Brain Injury Services (Northern Ireland) [2015];

(e) Quality assurance of the review of the handling of Serious Adverse Incidents reported between 1 January 2009 and 31 December 2013 [2014];

(f) Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland [2013];

(g) A Baseline Assessment and Review of Community Services for Adults with a Learning Disability [2013];

(h) Access to evidence based psychological therapies for adults who subsequently complete suicide [2013].

Complaints and Monitoring

[45] In addition each HSC Trust has a formal complaints mechanism which was initiated in the applicant's case.

[46] It is open to applicants to refer matters to the Northern Ireland Ombudsman if dissatisfied with the outcome of a complaint.

[47] The Patient and Client Council also provides practical support to patients and persons who receive treatments from Health and Social Care Trusts.

[48] Mr McAteer also drew the court's attention to what he described as practical arrangements within the statutory framework. These parallel processes create a system of continuous monitoring. He describes these in the following way:

> *"There are regular meetings at Assistant Director (Adult Mental Health Sub-Group) and Director level (Mental Health and Learning Disability Improvement Board) where issues are raised and discussed. This can include everything from service development, finance performance, implementation of new ways of working and specific issues which require rectification. Both groups are key components in discussion around existing protocols, guidance and procedures. They are forums where systemic issues can be discussed and regional solutions found. These groups meet regularly, with meetings pre-COVID-19 on a monthly basis. Since the start of COVID-19 meetings have been more frequent (at one point twice a week) to ensure the standards of care were maintained during the challenges of the pandemic. Specific examples of ensuring HSC Trusts meet their duty to provide care:*
>
> *(a) In the early stages of the pandemic in March / April 2020, the HSC Trusts were making plans to stand down talking therapies due to the infection risks involved when people were meeting face to face. This was discussed at the Adult MH Sub-Group where the Department's position that talking therapies represent an integral part of the stepped care model in mental health, and stepping down this service would mean the Trusts would not provide the standards of care expected. The Trusts were instructed to continue with talking therapies, albeit sometimes remotely and after individual risk assessments. The Department then sought recurring assurances that this was continuing in the form of regular reporting at the meetings. When the Department was assured that this was taking place, the reporting was stood down.*
>
> *(b) Throughout the pandemic pressures on mental health in-patient services has been significant, with bed occupancy regularly over 100%. Some of the Trusts, facing difficulties due to the increased demand and additional pressures on their workforce, adopted a practice of refusing*

> *out of trust admissions. This could have had the effect that a patient who needed admitted to a mental health in-patient ward would have been denied admission merely on the basis of where the patient lived (although there is no evidence this took place in practice). This practice was reported on a daily situation report on mental health bed pressures from the HSC Trusts to the Department. The Department considered that this would not meet the standards of care expected of mental health patients in Northern Ireland. This was communicated initially at the Adult MH Sub-Group, and then escalated to the MH and Learning Disability Improvement Board, where the Department notified the Trusts that this practice does not represent best practice and must stop."*

[49] He points out that each HSC Trust has a responsibility to provide an early alert to the Department if certain events take place. There are seven criteria for notification:

(i) Urgent regional action.

(ii) Contacting patients/clients about possible harm.

(iii) Press release about harm.

(iv) Regional media interests.

(v) Police involvement in investigation.

(vi) Events involving children/young people in care or receiving after care support.

(vii) Suspension of staff or breach of statutory duty.

[50] The Trusts have a duty to report each early alert initially by phone to the Department and then by writing to the Department and the HSC Board. This provides the Department with a monitoring tool to consider if action needs to be taken.

[51] With respect to mental health provision, Trusts report issues regularly. In many cases the events are outside the immediate control of the Trust, for example when in-patient wards are full or where a patient known to services has died. However, in some cases this relates to areas where the standards of care are not met and it has led to the Department taking immediate action to either seek action from the HSC Board to ensure the Trust remedy the situation or where the Department has taken action.

[52] When certain untoward events happens in a HSC Trust, a Serious Adverse Incident (SAI) review has to take place. These reviews, tiered in three levels, analyse the event and provide learning for the future. This often involves learning points for HSC Trust practices. The SAI reviews are conducted with a tiered level of independence.

[53] Across all these areas, if the Department considers the issue to be sufficiently serious the Department can ask the Trust to make immediate changes, or for the HSC Trusts or HSC Board to develop action plans to provide change. For example, in a recent level 3 SAI relating to a very serious incident in a HSC Trust, a number of recommendations were made for improvements as systemic issues which contributed to the incident were identified. The HSC Board subsequently developed an action plan, setting out actions that would address the recommendations in the review, and the Trusts have been tasked to carry out the actions. The HSC Board monitors progress and reports on progress to the groups mentioned above.

[54] Further, each year the HSC Board provides a Delegated Statutory Functions report to the Department detailing the requirements, processes and issues arising within Health and Social Care Trusts as reported under the Scheme for the Delegation of Statutory Functions. This includes delivery of mental health services, as a delegated statutory function. This provides a report from the HSC Board on issues identified as challenges and risks. Issues identified in the DSF work can then be fed back through the other channels of monitoring and communication, as discussed above.

[55] Finally, Mr McAteer informed the court that notwithstanding the matters already in place the Department has decided to carry out a fundamental review of regulation to ensure that the system of regulation of health and social care is appropriate to ensure the ongoing quality of services and safety of service users.

[56] The court recognises that it has not received affidavit evidence on many of these points but the court was concerned to understand the nature of current provision on this issue.

[57] Mr Morgan, on behalf of the applicant, is critical of the regime described above. In terms of the RQIA he suggests that it can only carry out a review, investigation or inspection if requested to do so by the proposed respondent. He suggests therefore that it does not actually investigate ongoing mental health treatment in a systemic manner in this context. Furthermore, even if it is required to carry out an investigation the fact that it does so at the request of the proposed respondent could undermine its independence. It seems to the court that this understates the powers of the RQIA as set out above.

[58] In addition, he suggests that a complaints mechanism, howsoever effective, does not have the same effect as a regime of inspection and regulation, particularly in the context of addressing any systemic and structural issues.

The Applicant's Case

[59] Quite properly the applicant does not base his claim on a breach of statutory duty under the 2009 Act.

[60] There is no express duty conveying a right of action in favour of the applicant in this regard. The statutory duties imposed on the Department under the 2009 Act are what has been described as "target duties." There is ample authority and precedent for the proposition that these duties and obligations do not give rise to enforceable rights on behalf of individuals.

[61] The applicant bases his claim under the Human Rights Act 1998 seeking a declaration on the basis of alleged breaches of Article 2, Article 3 and separately Article 14 in conjunction with Articles 2 and 3 of the European Convention on Human Rights (ECHR).

Articles 2 and 3 ECHR

[62] In relation to the arguments based on Articles 2 and 3 it is well established in both European case law and domestic law that a sufficient evidential threshold is required before an applicant's rights can be engaged or breached.

[63] The matters in respect of which the court received evidence, were dealt with comprehensively by the letter from the Director responding to the applicant's complaints which has been set out earlier in this judgment. Any consideration of an Article 2 or Article 3 complaint needs a factual context against which the court can assess whether there has been any breach. The breakdowns in communication identified in the Director's letter should not have happened. However, the faults identified could not, in the court's view, be elevated to sustain a case that the system of regulation and supervision which exists in relation to the regulation and supervision of mental health services is in breach of the State's Article 2 or Article 3 obligations. There is in place a multi-layered system in Northern Ireland in respect of the provision of mental health care and the regulation of that care. The fact that that system differs from the one in England and Wales does not render the system unlawful. Neither does the fact that it could and, indeed, may be improved render it unlawful.

[64] Article 2(1) requires that:

> "Everyone's right to life shall be protected by law."

[65] This places a positive obligation on States to ensure that there are in force suitable laws for the protection of human life and to provide the necessary means of enforcing those laws. The Convention cases in relation to the positive duty to protect life have for the most part dealt with criminal law provisions to deter the commission of offences against the person, protections against intentional killing, obligations to investigate deaths, prevention of, and, investigation into deaths in custody and risks faced by those subject to deportation.

[66] It is right to say that there is a social dimension of the duty to protect life and this can extend into the issue of health care. Thus, in *Cyprus v Turkey* [2002] 35 EHRR 231, it was held that there would be a breach of Article 2 if life-saving medical care which is available generally is withheld from an individual.

[67] Mr Morgan referred me to the principle established in the case of *Oneryildiz v Turkey* [2005] 41 EHRR 20. In that case it was stated that the positive obligation:

> *"… entails above all a primary duty on the State to put in place a legislative and administrative framework designed to provide effective deterrents against threats to the right to life …"*

[68] In the context of that framework the court went on to say at paragraph 90 that it should include regulations which:

> *"must also provide for appropriate procedures, taking into account the technical aspects of the activity in question, for identifying shortcomings in the processes concerned and any errors committed by those responsible at different levels."*

[69] The context of that case concerned allegations of the right to the protection of life in the environmental field. In that case the applicant's relatives had died as a result of an explosion at a municipal rubbish tip. There were 39 deaths in total. There had been an explicit notice of a potential risk to life. The facts are far removed from the circumstances of this application. As always context is essential.

[70] In this case the applicant's medical condition is such that he is a suicidal risk. In terms of the State's obligations it is clear that there is in place a State sponsored provision of ongoing medical care and treatment to the applicant. There is also in place a system of regulation and supervision of that care. In these circumstances it cannot be argued that the State has failed to provide appropriate health care in the context of Article 2.

[71] In relation to Article 2 the applicant's affidavit evidence falls well short of that sufficient to establish a real and immediate risk to his life as a result of a failure to regulate or inspect mental health treatment provision provided by Health and Social Care Trusts.

[72] In terms of Article 3 it is well established that the treatment about which a person complains must be of sufficient severity to constitute inhuman or degrading treatment within the terms of Article 3. Article 3 provides protection against only the most serious ill treatment; the treatment must attain a minimum level of severity before there is a violation. Perhaps the leading authority on this issue is *Pretty v United Kingdom* [2002] 35 EHRR 1 at paragraph 52 where the court said as follows:

> *"As regards the types of 'treatment' which fall within the scope of Article 3 of the Convention, the Court's case-law refers to 'ill-treatment' that attains a minimum level of severity and involves actual bodily injury or intense physical or mental suffering (**see Ireland v The United Kingdom**. Where treatment humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3 (see amongst recent authorities, **Price v The United Kingdom**, and **Valašinas v Lithuania**.) The suffering which flows from naturally occurring illness, physical or mental, may be covered by Article 3, where it is, or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible."*

[73] Clearly, there can be no suggestion that any alleged treatment in the context of this case had the purpose of humiliating or debasing the applicant. This, of course, does not rule out the finding of a violation of Article 3.

[74] Mr Morgan referred me to the authority of *R(Munjaz) v Mersey Care NHS Trust* [2006] 2 AC 148 where the House of Lords held that a policy that gives rise to a significant risk to a breach of Article 3 of the ECHR is unlawful under the Human Rights Act 1998. That case involved the seclusion of those detained in mental health hospitals which the court held was capable of breaching the Convention, if improperly used. Again, context is important. The court held that the fact that a secure hospital departed from a Code of Practice on seclusion issued by the Secretary of State did not breach Article 3 as the hospital's policy, properly operated provided sufficient protection.

[75] The court takes the view that the matters claimed of by the applicant fall well short of the minimum level of severity which is required to establish a breach of Article 3.

[76] Given the court's view on Articles 2 and 3 the question of Article 14 does not really arise. However, for the sake of completeness this argument can be dealt with in short form. In order to establish a breach of Article 14 in conjunction with another

Convention right an applicant must establish the four steps set out *R(Stott v Secretary of State)* [2018] 3 WLR 1831:

> *"(i) The treatment must be in the ambit of substantive right.*
>
> *(ii) The difference in treatment must be on grounds of status.*
>
> *(iii) An analogous situation must exist.*
>
> *(iv) There is lawful justification for the difference in treatment."*

[77] The applicant in this case falls down on both the second and third questions. The status put forward by the applicant is a Northern Ireland resident. This status is contrasted with residents in England and Wales. In the court's view those who reside in England and Wales are not in an analogous situation as residents in this jurisdiction for the purposes of an Article 14 argument in this context. The proposed respondent has no role whatsoever in the regulation or inspection of provision in any other part of the UK and therefore cannot discriminate on how it carries out such regulation or inspection across different jurisdictions. Differences arising from different approaches to similar matters by different devolved governments is itself a function of devolution and not a proper basis for a discrimination claim.

[78] The court has concluded that the applicant has simply not established a sufficient evidential basis for an argument based on Articles 2 and 3 alone or read together with Article 14. The applicant forcefully argues that there is a public interest in the court conducting a review of the adequacy of the regulation and inspection of mental health services in the community given the high prevalence of mental illness in the UK, and Northern Ireland, in particular. It is suggested that the general issue of the regulation of mental health treatment in Northern Ireland is of "elevated importance" because of public concern about the adequacy of such treatment.

[79] There is no doubt that the question of the provision (which is not an issue in this case) and regulation and inspection of mental health services is an extremely important matter. Mr Morgan makes a compelling and compassionate case for the introduction of a regime in this jurisdiction similar to that which exists separately in England and in Wales. However, this is classically a matter of macro political policy and not one which is suitable to review by a judicial review court given the constitutional constraints that apply.

[80] The court is conscious that it is dealing with a leave hearing and of the modest threshold for the grant of leave on the merits in a judicial review application.

[81] However, the court considers that this case is not arguable and has no reasonable prospects of success. It has come to this conclusion on the basis of the evidence submitted on behalf of the applicant. It is not satisfied that it is arguable that there is any prospect of establishing a breach of Articles 2 and 3 or a breach of Articles 2 and 3 in conjunction with Article 14 for the reasons set out above.

[82] The court fully recognises the importance of the matter raised by Mr Morgan in his able submissions. The court equally recognises the plight of the applicant and the difficulties that arise from his very serious medical condition.

[83] The court was anxious to understand the nature of existing provision in relation to regulation and accountability for the actions of health and social care trusts in the provision of services to patients such as the applicant. It considers that the current regulation of mental health treatment in the community in Northern Ireland is lawful and notes that it is the subject of ongoing review.

[84] In essence the applicant is urging the court to direct that the proposed respondent introduce legislation in accordance with that in England and in Wales. This is classically a matter of macro policy and not one which is suitable for intervention or review by the court. It is clear from the information set out in this judgment that there is in place a system of supervision and regulation of mental health services in the community. Mr Morgan's submissions indicate that a credible case can be made for an improvement in and strengthening of those arrangements. No doubt that is something that will be considered in the impending review of arrangements.

[85] However, the court has concluded that the applicant has not established an arguable case that the existing arrangements are unlawful or that the court has a role to play in intervening by way of declaration or mandatory order.

[86] In the circumstances the application for leave to apply for judicial review is refused.