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Case No: PTA/2/2014
PTA/1/2014
PTA/8/2013

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20/11/2014

Before :

MR JUSTICE OUSELEY

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Between :

DD	**Claimant**
- and -	
SECRETARY OF STATE FOR HOME DEPARTMENT	**Defendant**

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- -

Dinah Rose QC and Charlotte Kilroy (instructed by **Birnberg Pierce & Partners**) for the **Claimant**
Jonathan Hall QC (instructed by **The Treasury Solicitor**) for the **Defendant**

Hearing dates: 14th and 15th October 2014

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Judgment

MR JUSTICE OUSELEY

1. This is the judgment on a preliminary issue in an appeal by DD against the revival, on 3 July 2014, of a Terrorism Prevention and Investigation Measure, TPIM, under the TPIM Act 2011. The substantive appeal will not take place before 20 March 2015, in large measure because of the timetable for the disclosure process under CPR 80. The Appellant's mental health and the impact of the TPIM upon him has given rise to the expedited hearing of the preliminary issue, an issue of a sort which would usually be dealt with at the substantive appeal.

2. The issue, embodied in an Order of Cranston J, agreed after some argument before him, is: "whether the imposition of a TPIM on DD is a breach of his rights under art.3 ECHR, and consequently a breach of s6 HRA."

3. Although s16 (1) (b) of the 2011 Act requires the Court to consider whether the relevant conditions were met when the TPIM was imposed, here the date of revival, and whether it continues to be met, the reality is that the focus of this hearing was rightly on the current situation of DD. If Article 3 is breached by the continuation of the TPIM as of now, the past adds little to that decision; and if not now breached, it certainly was not breached in the past since it is the deterioration in DD's condition to its current level which is the strongest part of his case.

4. I ruled at the outset of the hearing that the closed evidence served in the appeal was not admissible in this hearing. The disclosure process in CPR 80 had not been undertaken; the appointed Special Advocate had not given notice to the court that she did not challenge the application to admit closed evidence and no hearing had been arranged. I accepted that I could not therefore consider closed evidence. I did not accept the contention of Mr Hall QC for the Secretary of State that the Order of Cranston J was intended to operate as a general consent to its use, nor that silence from the Special Advocate should amount to an unnotified consent. The reality is that the position in the text of Cranston J's Order of the obligation to serve closed evidence has more to do with its timing occurring before this hearing than with its admissibility in this hearing. The whole disclosure process is envisaged in the Order to take place after this hearing. The closed material in question was the full appeal closed material rather than a smaller bundle bespoken for this hearing.

The background to the appeal

5. DD is a Somali national, who arrived in the UK in 2003 and shortly afterwards was granted asylum and indefinite leave to remain. In May 2008, he was charged with fund-raising for Al-Shabaab. He was remanded in custody. He was acquitted in July 2009, largely admitting the acts alleged but saying that they were done in defence of Somalis in Somalia; he was released. In October 2012, a TPIM was imposed; an appeal was lodged but later withdrawn. Its terms were materially the same as now. On 8 April 2013, DD was charged with breaching the TPIM in February and March 2013; he was remanded in custody; he pleaded guilty to 3 counts of breaching the TPIM, (breach of the restrictions on the use of electronic equipment and on association) and was sentenced to 9 months imprisonment. On

25 April 2013, because he was in custody, the Secretary of State revoked the TPIM, only to revive it on his release from prison on 23 August 2013. He appealed against that revival of the TPIM in September 2013.

6. However, on 20 September 2013, DD was again arrested for breaching the TPIM, remanded in custody and the TPIM was therefore revoked. He again pleaded guilty, in April 2014, to two counts of breaching the TPIM, (unauthorised meeting and use of a computer at the same address) for which he was sentenced to 15 months in custody, and from which he was released on licence on 6 May 2014. The TPIM was revived: DD appealed against that decision. It was during this period of custody, and it seems as early as October 2013, that DD first came to the attention of psychiatrists, as I shall come to.

7. DD's period of licence starting on 6 May 2014 did not last long. On 8 May he was again arrested and charged with breaching the TPIM; he was remanded in custody. (It was said that he had purchased a television capable of connecting to the internet, and had met the person who came to the house to connect it.) On 3 July 2014 he was again released from custody. The TPIM had been revoked again on 21 May 2014, because DD was in custody. It was revived on 3 July and DD appealed against that revival.

8. There was a further alleged breach of the TPIM in August 2014, but the CPS decided not to prosecute following representations on behalf of DD about his mental health.

The national security justification for the TPIM

9. The summary assessment by the Security Service of the risk DD poses comes under five heads. First, although a refugee from Somalia, he returned there in 2007, with the associate who was tried with him in 2008 and also acquitted. They met senior Islamist extremists and couriered funds and equipment to Somalia for terrorism-related purposes.

10. Second, until the TPIM in 2012, DD had been recruiting, radicalising, assisting and guiding individuals to travel to Somalia for terrorism –related activity.

11. Third, DD was involved in administering, maintaining and contributing to extremist websites. He had created his own extremist websites, and possessed extremists documents and videos praising global jihad and martyrdom. Later, and up to the TPIM in 2012, he had maintained and contributed to pro-Al Shabaab websites.

12. Fourth, he raised money for Al-Shabaab, and latterly up to 2012, did so as part of a wider UK European and East African network of Islamist extremists. Fifth, he intended to travel again to Somalia for terrorism –related purposes, an intention which the TPIM may have lessened. There is no dispute about any of that, for the purposes of the preliminary hearing only.

The current version of the TPIM

13. DD is required to live at his home in Birmingham, and be inside between 21.00 and 07.00, unless permitted to be away. Home is a large house, where he lives with his wife and their seven children, aged between 19 years and 4 months. He is not permitted travel documents.

14. He can only use one bank account; and cannot hold or withdraw more than £200 cash in a week; (increased recently from £100, a sum which he found "burdensome and intrusive", especially doing the family shopping). He is restricted in the property which he can own without giving notice to the Home Office, and in the transfers of money he can undertake.

15. There are restrictions on whom he may associate with: named persons he may not associate with in the absence of Home Office permission, and other persons, requirements as to what he is to do if he meets people by chance; and exceptions to the requirement, including lawyers, health care professionals, those he meets for the purpose of work or study if previously notified, and attending prayers at a mosque where, however, he may not lead prayers. He cannot lecture or participate in broadcast discussions or preach.

16. There are four conditions which DD finds particularly stressful. First, the restriction on the use or possession of electronic communication devices, because of its impact on two of his children. His oldest child has physical and mental disabilities, and is wheel chair bound, but the next two, aged 17 and 15, need to use a computer for school work. He is allowed one computer with internet access by a fixed line, but this has been adapted to prevent the use of the USB ports and thus use of a memory stick. He, but not his wife or children, requires Home Office permission before accessing any website for the first time. His present computer broke, and the time taken to repair it and to refit the cage which prevents the connection of unauthorised devices means that he has been without it for several weeks, and continues to be without it. This has created problems for his children at school for which he feels responsible.

17. Second, he finds the requirement to report to the police station extremely "aversive" or distressing; this he has to do daily between 1 and 2pm. The Security Service had been prepared to reduce that to 5 days a week, but since he was on bail following his release, and that required 7 day reporting, no variation had in fact been made. However, the 7 days a week requirement for bail was itself only the reflection of the TPIM. During the hearing, the SSHD agreed that the reporting requirement would be varied, so as to cover only 4 days a week.

18. Third, he is excluded in the absence of specific Home Office permission from one defined area of Birmingham and one defined area of Leicester, and a range of places specific and generic, such as travel agencies, money exchanges, shops providing electronic communication devices, and stations and ports with overseas connections. This exclusion was extended in May 2014 to cover an area where the Security Service said that DD had met extremist associates in breach of the TPIM. The specific problem DD raised is that, until very recently, his health care centre was in an excluded area, so that he needed permission from the Home Office, which can take some time from the making of a request, to go there for treatment.

19. Fourth, the one which he finds significantly the most troublesome: the electronic GPS tag, fitted to his ankle. This has become the focus of paranoid delusions. Its purpose is to monitor, not just the curfew, but also other requirements, notably DD's location outside the home. The Security Service sees this as the most effective way of monitoring compliance with movement restrictions, reducing his ability to engage in terrorism –related activities without detection, and deterring absconding or entry to the excluded areas, which was integral to the TPIM's effectiveness and to the Security Service's efforts to prevent him engaging in terrorism-related activity.

The mental health evidence

20. Dr Quinton Deeley, who gave evidence on behalf of DD, is a consultant psychiatrist at Maudsley Hospital, and a senior lecturer at the Institute of Psychiatry at King's College, London. Professor Fahy, who gave evidence on behalf of the Secretary of State, is a Professor of Forensic Mental Health at the same Institute. He had been a consultant psychiatrist at the Maudsley. They were equally well qualified and expert for the issues in the case. Each was independent, careful and fair in their evidence. There was nothing to choose between them in that respect. Dr Deeley had had longer and more recent experience of DD, which is an aspect I shall have to consider. There was however a large measure of agreement between them reflected in their Joint Report and further in oral evidence.

21. Dr Deeley had produced five material reports over time. The first, dated 12 January 2014, and based on interviews in late December 2013 and early January 2014, was prepared while DD was in Belmarsh awaiting trial on charges of breaching his TPIM. I take the background to DD's mental health from that report, the purpose of which was to investigate background mental health difficulties and to assess DD's overall level of functioning. DD's solicitors, Birnberg Peirce, had become concerned about deterioration in his mental health after his arrival in Belmarsh on those charges, and Dr Cumming, the attending psychiatrist in Belmarsh, was said to be sufficiently concerned to consider the possibility of transfer to Broadmoor.

22. In 1991 or 1992, when DD was 14 or 15, his uncle, aunt and two of their children were killed in Somalia. Their bodies were kept in the family house for three days as the warlords would not allow their burial; the bodies smelt and became bloated before they were buried in front of the house. DD left Somalia for Dubai in 1996-2001, where he worked as an imam. He then lived in Denmark for two years before returning to Somalia in 2003.

23. In 2003 his father, older brother and brother in law were murdered in front of him and family members by militiamen, and a sister was raped by them. He was kidnapped and held for ransom for two weeks with others; he saw a woman and her children being severely beaten.

24. He then came to the UK, where he worked as an imam. His brother was killed and his mother died in 2007. This was when his mood lowered and he started to hear noises and voices associated with his experiences in the strife in Somalia. Although his mood improved when his family joined him in 2007, his

imprisonment in 2008 and his trial were associated with a deteriorating mental state, which improved after his acquittal and release in 2009. While he was in prison in 2008, his wife had been admitted to a psychiatric hospital after she tried to kill herself.

25. He said that in 2010, 2011 and 2012, the Security Service had tried to persuade him to work for them, offering him money and a house, but in 2012 had threatened to put him under real pressure if he refused. He gave an interview to Voice of America, shortly after which he was placed on a TPIM, which he regarded as linked events.

26. When he was put on a TPIM, he went to his GP because he was feeling scared, losing his memory, putting on his alarm to remind him to report to the police, and losing motivation, including the motivation to pray. He received medication.

27. DD's current experience of voices included women and children screaming for help, voices talking how MI5 wanted to harm his family, to arrest him and tag him on release. He heard MI5 officers and police talking to him; some spoke to him in Somali on the TV. Voices told him to harm himself before MI5 killed him. He refused to eat food in prison unless it was sealed food bought from the canteen, because he was convinced that MI5 would poison him with prison food. His visual hallucinations included seeing a Somali warlord on the wing, his dead father who came to see him in his cell, and MI5 officers who came in to his cell to threaten him. Dr Deeley saw DD slap himself forcefully and was told that a voice had told him to do that. He shook his head from side to side to interrupt the voices.

28. DD preferred being in Belmarsh to being outside, he said to Dr Deeley, because he would have to wear a tag, which emitted a noise like radio static. "Wearing a tag- imagine in the shower, with marriage, with voices". A "normal voice" tells him to remove the tag, which he knew would create problems for him.

29. Dr Deeley diagnosed DD as suffering from PTSD, with generalised mental and physical symptoms of anxiety, worsened in association with the deterioration in his depressive and psychotic symptoms. He also had a high score on the Beck Anxiety Inventory. DD was also suffering from a "schizoaffective disorder, depressive type", with symptoms of psychosis, including "first rank" symptoms of schizophrenia, based on the auditory and visual hallucinations, persecutory delusions, and the referential delusion that the police were talking to DD in Somali through the television. His depressive symptomatology was severe on the indications of the Beck Depression Inventory.

30. The onset of depression in 2007, after the death of his brother and mother, was associated with auditory hallucinations, suggesting a close relationship between depressive and psychotic symptoms, exacerbated by psychosocial stressors such as imprisonment or perceived harassment by the authorities. His mental state had continued to deteriorate in prison.

31. DD did accept after preliminary discussion with Dr Deeley that some of his symptoms might be attributable to mental illness rather than reality; he was keen to seek treatment for the symptoms. DD had been taking a daily dose of 10mg of olanzapine, a standard anti-psychotic medication, for several weeks. However, his

insight into his mental health problems and "reality testing" was limited at the present. "His mental suffering associated with these mental disorders is considerable".

32. Dr Deeley suggested that transfer to a psychiatric hospital for assessment would be appropriate, and that DD was not fit to stand trial currently.

33. Between that report and Dr Deeley's next report, on 6 March 2014, Dr Cumming sought an opinion to help in considering a possible admission to hospital, while remaining cautious about whether DD had a mental illness. He described symptoms, much as Dr Deeley had done, but dating back to when he had seen DD on referral in October 2013. He noted that there were many occasions when DD appeared bright, and settled without overt psychotic symptoms. Dr Memon, a Consultant Forensic Psychiatrist, then interviewed DD, considered the medical notes, and Dr Deeley's report. He concluded that DD was most likely suffering from paranoid schizophrenia, with the severity of his symptoms reduced by the olanzapine; for further improvement he recommended that the dose be increased. He thought that the risk of self-harm was reducing. DD's treatment should continue in prison.

34. Dr Deeley's next report is dated 15 April 2014, based on an interview conducted ten days after Dr Memon's. DD was still in custody. His symptoms were reduced. His scores in the Beck's Anxiety and Depression Inventories were reduced from high to moderate/mild. His mood was improved. DD thought that this may have been due to the medication, and he had moved to a better place on the wing with more time for association. Dr Deeley concluded that DD was recovering from "a very significant episode of mental illness which emerged in the context of recurrent severe traumatic experiences in Somalia", followed by stresses associated with his previous prosecution, imprisonment, contact with MI5, and the stresses of the TPIM, including the prosecutions and time in custody for breaches. If released from prison, DD would require treatment and support from a community health team. But it was "likely that he would find the resumption of a TPIM to be stressful which may increase the risk of deterioration of his mental state."

35. DD was released from prison on 6 May 2014, but he was back in custody for allegedly breaching the conditions of the revived TPIM on 8 May 2014. Birnberg Peirce were concerned about the effect of this on DD's mental health. Dr Deeley interviewed DD over the video –link from their offices. Dr Deeley described him as having lowered mood and features of depression; he appeared "more agitated and anguished than on the three previous occasions" Dr Deeley had seen him. "He was acutely agitated and depressed, expressing ideas of hopelessness and a sense of despair about being trapped in a cycle of recurrent alternation between imprisonment and a TPIM regimen. He expressed thoughts of wanting to end his life, but also resisted these thoughts. He had prominent psychological and bodily symptoms of fear and anxiety associated with recollections of traumatic experiences."

36. The return to prison had been associated with a significant deterioration in symptoms of mental illness, an acute deterioration in mood associated with significant mental distress and thoughts of suicide that he was able to challenge,

and worsening symptoms of PTSD, compared to the improved position in March 2014. DD believed that the TPIM was a form of punishment for his refusal to work with MI5, the conditions on it he found intrusive and humiliating, and he viewed them with anxiety, but he still wished to leave prison to support his family. DD was likely to be confused at times, with poor judgment.

37. On 18 June 2014, three weeks after his previous interview, Dr Deeley interviewed DD again over the solicitor's video link for the purpose of his fourth report dated 26 June 2014. This report addressed the specific impact of the TPIM and its conditions, but at a crucial point dealing with the tag the link ended. So I deal with those impacts from Dr Deeley's final report.

38. DD's mood was less agitated and anguished than three weeks before, but he was low in mood, expressing ideas of hopelessness, trapped in a cycle alternating between TPIM and prison. He would not act on suicidal ideas.

39. Dr Deeley expressed the opinion that release from custody to a TPIM on the terms previously in force would "maintain and exacerbate [DD's] severe mental health problems, including psychotic symptoms (such as paranoid delusions and auditory hallucinations), severe symptoms of depression, and severe post-traumatic symptoms." Dr Deeley based that opinion on (1) DD's belief that the TPIM was a punishment for refusing to co-operate with MI5, (2) the stresses associated with specific TPIM conditions which created practical difficulties and constraint in everyday life; the sense of humiliation created by the tag for washing and having sexual relations with his wife, and the perceived impact of the conditions on his family,(3) acute stresses associated with the TPIM were associated with an exacerbation of psychotic symptoms, (4) psychotic experiences related to his view that the TPIM was a punishment, and (5) evidence that DD's symptoms of depression and PTSD worsened under conditions of stress. DD might also have difficulty complying with the TPIM in those circumstances.

40. A continued pattern of release, revived TPIM, breach, prison, release, TPIM and so on would be likely to "perpetuate and exacerbate [DD's] severe mental health problems causing significant mental suffering and a worse prognosis…." It would confirm his sense of hopelessness and persecution, and deprive him of or limit his opportunities to fulfil a productive role in his family, and to re-establish friendships, both of which promote recovery from severe mental illness and reduce the likelihood of relapse.

41. The next report in time was that of Professor Fahy, dated 5 August 2014, and based on an interview on 11 July 2014. DD had been released from custody eight days earlier and the TPIM had been revived at the same time. This is therefore the first report in the series of reports when DD had not been in custody. Professor Fahy accepted in oral evidence that DD's release not long before would have contributed to the improvement he reported.

42. The index events and most of the psychiatric history add nothing to Dr Deeley's reports. Currently, DD reported that the television had stopped talking to him; he no longer had visual hallucinations, but continued to experience auditory hallucinations, including the voice of the MI5 agent, and the voices of women and children pleading. The family environment helped distract from those experiences,

but they became more prominent alone in a silent environment. He was always sad. The feeling that he had no future had been the main problem in recent years. He continued to feel in danger from the police and MI5. His motivation had reduced, he felt lazy and enjoyed watching the television. He no longer attended mosque, as he feared committing an unintended breach of the TPIM. The only noteworthy abnormality in interview was DD's occasional vigorous side to side shaking of his head.

43. During the discussion of psychotic symptoms, DD said that he believed that "they" could read his thoughts, download them and insert others. He also reported that sometimes he had heard voices from the tag, and sometimes believed that it contains a microphone and camera, which has led him to refrain from sexual relations with his wife. There are also times when he has been concerned that the tag contains an explosive device. Professor Fahy summarised the GP and prison medical records, and Dr Deeley's four reports.

44. Professor Fahy was of the view that DD's post-trauma symptoms no longer justified a diagnosis of PTSD, though it was possible that they had done so in the past. The onset of deterioration in his mental state went back to 2007, when he describes the start of psychotic symptoms, with auditory hallucinations becoming more intense and frightening in 2011. There had been no reference to mental health symptoms however in medical records until December 2012.

45. This suggested an "evolving psychiatric disorder" but its lengthy evolution was atypical. It was unusual for hallucinations to include the sound of gunshots as well as voices. The atypical course and lack of reference to symptoms could be attributable to cultural factors, attributing voices to spirits, and overlapping post traumatic symptoms could account for the different forms of auditory hallucinations. The results of the clinical examination were largely consistent with those of Dr Deeley. Professor Fahy, however, attributed the psychotic symptoms to a primary psychotic disorder rather than as secondary to mood disturbance which was Dr Deeley's conclusion. DD satisfied the diagnostic criteria for schizophrenia. Professor Fahy also concluded for a variety of reasons that DD's symptoms were probably genuine.

46. His concluding diagnosis was that DD suffered from a genuine mental illness, schizophrenia. The post-traumatic and mood symptoms were not intrusive or disabling at the time of interview and did not justify an additional psychiatric diagnosis at present. The cause of the psychotic illness was likely to be "multifactorial", including the family history in which his mother suffered a psychotic illness, "and a remarkable accumulation of life stressors".

47. DD had received appropriate treatment. A comprehensive treatment plan would include the regular review of medication by a consultant psychiatrist, psychosocial support delivered by the community psychiatric nurse and psycho-education about the causes and management of his symptoms. A psychologist could also be helpful in dealing with treatment resistant auditory hallucinations. He would need to continue with this treatment for 2-3 years, or longer if the symptoms continued.

48. In response to specific questions, Professor Fahy said:

> "The chronology of his condition suggests that stressors involving the criminal justice system from 2008 onwards have made a substantial contribution to the cause of his illness. Schizophrenia is a mental illness which, in the majority of cases, follows a chronic relapsing course. Relapses can be precipitated by stressful life experiences. In DD's case his symptoms have responded well to the initiation of treatment. The duration of his illness is likely to be chronic, especially if his account of symptoms being present since 2007 is accepted. However, it is my opinion that the course and outcome of his condition can be alleviated by appropriate treatment. Resolution of his legal situation would remove one of the perpetuating factors influencing his condition."

49. He found it difficult to give a precise prognosis, but thought that DD was likely to continue to experience auditory hallucinations, "albeit at reduced intensity and with reduced associated distress, for the foreseeable future."

50. Professor Fahy was asked to what extent the imposition and revivals of the TPIM had had an impact on DD's mental health. He replied:

> "The chronology of DD's mental illness suggests that stresses arising from his contact with criminal justice services since May 2008 have been a major factor in the cause and course of his mental illness. The TPIM has culminated in restrictions on permitted activities, family stresses (probably exacerbated by his wife's mental health problems) and periods of imprisonment. Therefore, it is my opinion that the TPIM has impacted substantially on DD's mental health."

51. The global impact of the TPIM had increased DD's stress levels, but most measures caused stresses which were probably no different for DD if he were not suffering from mental illness.

52. The restrictions on the withdrawal of money and on children's access to the internet were experienced as "especially burdensome and intrusive", with DD reporting distress at the adverse effects of those restrictions on his family. But he continued:

> "The measure that requires wearing of an electronic monitoring tag has had a specific impact on DD's mental health, as the tag became a focus of paranoid beliefs, especially when his illness was untreated. Persecutory beliefs about the tag have now reduced, but for a person with paranoid delusions, the compulsory wearing of a tag will lead to more stress and paranoid ideation than in the ordinary resilient individual."

53. The TPIM made DD feel that he could not progress in any domain of his life, leading him to be very pessimistic about his future, with fear of unintended or unwitting breaches causing him to withdraw from some permitted social and religious activities. These detrimental effects could be lessened by the removal of the tag, by a review of the financial restrictions on the withdrawal and holding of cash, and seeking to provide the children with educational access to a computer and internet access. The computer restriction was stressful because of the effect on the children, which made him very upset.

54. Professor Fahy's concluding comment was:

> "It is evident, based on my assessment of DD, that his condition has improved substantially since he started appropriate antipsychotic medication. At the time of the assessment he also expressed relief at his recent release from prison. It is likely that continued treatment will reduce some of the stressful effects of the TPIM measures (for example, persecutory ideation focused on the electronic monitoring tag has already reduced). The other inconvenience and stresses caused by the TPIM measures can be viewed as generic, and likely to cause a burden and stress for ordinary resilient individuals. This effect is somewhat exaggerated in DD's case owing to his mental illness, probably giving rise to a modest exacerbation of residual symptoms."

55. The last report was from Dr Deeley, dated 28 August 2014, based on a three hour interview six days before, at DD's solicitors' offices. DD explained that, on 4 August 2014, he had gone to the mental health team as he had started to become increasingly anxious, to sleep badly, to hear voices and crying women and children, worse than upon his release; he had become very low in mood. He was seeing his father again. The hospital had increased his olanzapine from 15 to 20 mg daily, with a sleeping tablet, which had significantly reduced his acute severe mental distress. He had also experienced a more recent deterioration in his mental state since visiting the Probation Service, hearing threatening voices from MI5, and with intrusive and distressing recollections of traumatic experiences. He no longer had concerns about food as he was not in prison.

56. At the interview itself, he said that he still had problems with sleep, was scared and sad when he awoke, feeling low and anxious, unable to do anything until he had reported to the police station, after which he felt better. He scored in the severe range on the Beck Depression Inventory, with severe and moderate symptoms on the Anxiety Inventory. DD said that he had always "regularly recollected" the traumatic experiences, even before the TPIM, varying between daily and two to three times a week.

57. Dr Deeley's report then turned to the effect of the TPIM and its conditions, as recounted by DD. The residence condition was not a major problem. The travel restriction on him affected his family's ability to visit family in other countries, as they felt they could not go without him. Nor could he contact them without permission as a result of the TPIM; and when he had asked two years ago for

permission to contact his two children in Ireland from another marriage, he had had no reply from the Home Office, so he had not asked for permission to speak to anyone at all. The exclusion areas prevented him going to an area popular with the Somali community, and he could not take his children there, so they had to go by bus. He did not go to the Somali mosque, because he did not want to say why he could not lead prayers; he went to a Pakistani mosque where he had explained his situation.

58. The need to comply with directions given by a police officer made him terrified and sad whenever he saw one. The cash restriction of £100 was a problem for the family shopping, as his wife therefore had to come with him and consequently the children as well. Notifying the Home Office of property and car rental and ownership was not a problem. The restriction on the computer at home affected the school work of two of his children; he had to get permission to visit websites on the first occasion, but regarded it as a breach of the condition if his 4 year old went on YouTube; and he had forbidden his children from using the internet in case it led to a breach by him. The restrictions on meeting people had meant that he had no friends and could not speak to people in the streets, so he was scared and lonely. The requirement to have permission to work or study had meant that he did neither, since the college he was going to had the internet.

59. The daily reporting restriction was "very difficult"; he was scared every time he went. He found it "extremely aversive", in Dr Deeley's words, or distressing; his wife often had to remind him to go. But the requirement to allow his photograph to be taken by a police officer had not been used and so was not a problem.

60. DD told Dr Deeley that the conditions on reporting to the police, on the use of the internet and on the holding of cash were three he would most want to change, but the main problem was the GPS tag. He found it heavy; it hurt his ankle and affected the skin beneath it, and was very uncomfortable at night. He had been told in Belmarsh, and was now convinced, that the tag contained a video-camera; his wife also believed that. That had led them to refrain from sexual relations, though now they did so covered up from the eyes of outsiders. DD held the firm belief that the tag also contained a bomb, which MI5 would eventually set off to kill him, as a punishment for not working with them. He also heard voices every few days telling him to take it off before he is killed.

61. Dr Deeley concluded that DD had limited insight into his conditions, but did recognise that medication could lead to some improvement in his symptoms.

62. Dr Deeley maintained his diagnosis of January 2014, and concluded that he also currently satisfied the criteria for PTSD. The causes of both PTSD and the depressive-type schizoaffective disorder, were multifactorial. The "key predisposing factor" for the PTSD was the multiple severe traumata he had experienced; exacerbating and perpetuating factors were likely to include causes of generally increased anxiety and stress, such as prosecution, the TPIM and its conditions, repeated imprisonment, anxiety about the effect on his family, and factors which reminded him of his past experiences. His family history of likely psychotic illness was a predisposing factor for the schizoaffective disorder, along with recurrent severe stressors, severe traumatic experiences in Somalia, litigation, perceived punishment by MI5 for not acting as an informant, and periods of

imprisonment associated with breaches, and the effect of it all on his family. Professor Fahy agreed with this in oral evidence.

63. The best treatment was medication under the supervision of a consultant psychiatrist, regular contact with a community psychiatric nurse, and treatment by a suitably experienced psychologist.

64. The revival of the TPIM upon DD's release from prison was affecting his mental health. It acted as an exacerbating and maintaining factor for both PTSD and the schizoaffective disorder. The auditory hallucinations and persecutory delusions were specific symptoms linked to the TPIM. The anxiety felt before reporting and improving afterwards showed a temporal relationship between symptoms and the TPIM. The impact of various conditions on his family and family life, for example the exclusions and travel restrictions, increased the general level of stress, sense of threat and persecution, powerlessness, and hopelessness, lowering his mood. His increased anxiety levels would lower the point at which he experienced the symptoms of PTSD. The isolating effect of the conditions deprived him of the social and occupational support which helped recovery from mental illness.

65. His mental state put him at risk of breaching various conditions: the belief that the tag contains explosives has made him close to removing it on a number of times, as have his other delusions about it. He found reporting very aversive. There was a risk that the effect of restrictions on him, affecting his children, would lead him to permit access to the internet by them, in breach of the condition, as he understood it.

66. The removal of what DD described as the four most onerous restrictions would be likely to ease the strain on DD's mental health. With the TPM continuing in force, DD's prognosis was poor; his health would not improve or would worsen. He agreed with Birnberg Peirce's proposition that "the imposition of the TPIM imposes an exceptional and continuing stressor upon a vulnerable individual, the impact of which is significantly more severe than the impact of such an order on a person in good or reasonably good mental health." This was because specific conditions, such as the tag, and the general effect of the TPIM (perceived as punishment), chronic threat of breach and return to prison, combined with feelings of hopelessness and powerlessness to exacerbate DD's mental ill-health problems.

67. The continuation of the TPIM would be likely to cause "serious damage" to DD's mental health as it would act as a maintaining and exacerbating factor for his severe mental health disorders. The longer it stayed in force, the worse the prognosis, and the more difficult the recovery, even after it had been removed.

68. Professor Fahy and Dr Deeley produced a joint report dated 3 October 2014. They agreed that DD had reported clinically significant PTSD symptoms from the events of 1991 and 2003, and at times had merited a diagnosis of PTSD. Professor Fahy, but not Dr Deeley, thought that they had reduced to the extent that such a diagnosis was not warranted, but could increase at times of stress. They agreed that DD had developed a psychotic illness with auditory hallucinations and paranoid beliefs, with symptoms evolving from 2007, but unreported to medical staff as DD attributed the symptoms to jinns or evil spirits. The difference in

diagnostic labelling was agreed not to be significant for these purposes. The causes were multifactorial, in which the positive family history of mental disorder, and the series of stressors in Somalia and after his detention, were important.

69. They agreed that they had found no evidence that DD had deliberately exaggerated his psychiatric symptoms, partly because of his relatively good response to medication, the nature of the symptoms and previous reticence in disclosing symptoms lest he be labelled as mentally ill.

70. They agreed that appropriate treatment included medication for the foreseeable future, psycho-educational, practical and psychological support from a community mental health team of consultant psychiatrist, psychiatric nurse with specialist psychological help, if required.

71. The conditions of the TPIM were agreed to be stressful and burdensome, and likely to be more burdensome for someone with mental health problems; the TPIM was likely to exacerbate psychotic symptoms. The tag caused a specific exacerbating problem for someone with paranoid psychosis, and it had exacerbated DD's symptoms. Although Professor Fahy thought that the problem had reduced to an extent at the time of his interview, he accepted that, based on Dr Deeley's latest assessment, the tag had exacerbated the psychotic symptoms. The TPIM was a focus for anxiety and pessimism, with DD fearing that innocuous behaviour could lead to recall to prison, and his withdrawal from many social and religious activities, which did not help recovery from his mental illness.

72. They continued:

> "We agree that the strain on DD's mental health could be eased by the removal of the electronic tag, reducing the restrictions on the amount of cash he can withdraw or hold, and by investigating measures that could provide the children with access to necessary educational use of computer equipment and internet access. Dr Deeley adds that removal of the condition of signing on at the police station would also be helpful, because this condition is associated with severe anticipatory anxiety and lowering of mood. In Professor Fahy's opinion, the removal of this condition is unlikely to make a substantial difference to DD's psychiatric symptoms. We make these comments on in a clinical capacity and we do not offer an opinion about the necessity for such restrictions in terms of security concerns."

73. They also agreed that it would be helpful if the restrictions were not an obstacle to DD attending medical appointments.

74. Dr Deeley expressed the view that the suffering caused by the TPIM could properly be described as severe; Professor Fahy thought that the distress was significant but mild when he had seen DD, who appeared to be coping.

75. This joint report did not and could not consider evidence of an incident in mid-September 2014, about which DD gave evidence in a statement, which I admit to the extent that it deals with that event. What happened, on DD's account, was this. There was a little more detail later from the SSHD. The computer had broken down before DD's release in July, and his wife had removed it for repair. After DD's release, DD and his wife decided not to have the computer back because of fear that the children would access unauthorised websites, not appreciating till 5 September that the requirement for prior permission before accessing a website for the first time only applied to DD and not to the other members of the family. On 9 September, DD's wife collected the computer from the repair shop, and delivered it to the police for them to fit the security cabinet which prevents the use of devices such as a memory stick. This work has still not been completed.

76. On 14 September 2014, three of his children came home from school saying that they were behind in their work because they needed a laptop and access to the internet. A teacher contacted DD to say that his son was falling behind, and to check if it was correct that they did not have a computer, which DD confirmed was the case; he did not explain why, not even to the extent of saying that it was being repaired. His wife started to cry; she felt very isolated. He blamed himself for the problems faced by his children. When he feels low, as he now did, the voices are worse, and he feels he cannot continue with life. When he woke on 15 September, he wrote a letter saying that he could not continue with life, and would kill himself by throwing himself under a train. He put the letter in the kitchen and left. His wife found it, followed him, and brought him home where he went to sleep. When he awoke he could not remember what had happened, but his wife showed him the letter, which made him worry that he would in fact kill himself one day. He called his mental health team; the police took him to hospital that evening, where he was seen and discharged, because, he says, he was seeing the team the next day, when they gave him medication which helped his mood. The notes of what he told the medical staff are consistent with his statement.

77. The experts were asked about this in their oral evidence. Professor Fahy accepted that the picture it showed was of a crisis, which was acutely distressing to DD, with the possibility of committing suicide contrary to his religious beliefs, while unaware of what he was doing. Professor Fahy agreed that he had been a little too optimistic in his report in the light of the deterioration in DD's condition. Dr Deeley described it as a form of suicidal ideation acted on to some extent. The absence of recall was a reaction which occurred under great stress, often associated with PTSD, further illustrating the severity of DD's mental health problems under current circumstances, and the continuing adverse effect of the TPIM conditions. Neither had spoken to DD about this incident.

78. Professor Fahy accepted, in oral evidence, in the light of Dr Deeley's last report, that his anticipation that DD would improve had not been realised, and in fact that DD had deteriorated significantly, with the return of symptoms which had lessened or disappeared, though he had never expected DD to be symptom free. DD's insight into the abnormal nature of his beliefs had receded and their intensity had increased again. He had not expected DD's depression to worsen, but he could have seen DD in a "honeymoon" period after release from prison the week before, where he had been improving. Signing on was a significant stress

factor making DD more anxious. This might be a short period of deterioration. DD's PTSD symptoms were also worse than when he had seen DD; given what Dr Deeley found, he saw no reason to disagree with Dr Deeley's views about that.

79. Professor Fahy's prognosis was that DD would be prone to crises from the TPIM and family problems. When they occurred, DD should be treated as would mentally disordered offenders who had been released and put on GPS tags and whom he dealt with: assessment of risk, supervised medication, out patient treatment, then with a community psychiatric nurse, and increasingly frequent contact, appointment with a psychologist and if necessary re-admission to hospital. DD was not getting the full care plan as he did not have a community psychiatric nurse. He would need medication and a nurse even if he were not on a TPIM, since he was quite unwell before then, and he needed ongoing treatment.

80. The offenders Professor Fahy referred to were those whose wearing of a tag enabled them to be released, as they understood, when otherwise they might not have been; but he said that his unit would not tag an acutely paranoid patient as it would become the focus of paranoia, exacerbating the condition and making treatment more difficult. If the tag became the focus of beliefs, his unit would stop using it, although that might mean a return to hospital. The TPIM, and especially the tag, exacerbated DD's condition, primarily his psychotic and unusual beliefs. It would be severely distressing for a person to believe that he was strapped to a bomb for 24 hours a day, though DD had not always reported that, and the intensity of such beliefs fluctuated. But the fact that nothing had happened so far could not be used by psychiatrists as a basis for dealing with it, as it was a persistent, firmly held but irrational belief. DD had recurrent stressful experiences, and so long as they occurred, he would experience acute reactive deteriorations. But if the tag came off, the persecutory beliefs would not necessarily take on a different form, because there was something special about the tag, as a piece of technical equipment, forcibly attached to the body, which with a paranoid person invited suspicion. It was not a normal item such as a television; if he had paranoid symptoms in relation to a television, as he has had, that would probably continue.

81. Dr Deeley, in oral evidence, agreed that DD's symptoms had existed before the TPIM, but that the TPIM had exacerbated them; he had had paranoia about MI5 before the TPIM, but not about MI5 punishing him with the TPIM. The belief that MI5 wanted to kill him came and went; he held it more in recent times. Dr Deeley did not know whether he currently held that belief, but the fact that DD had not mentioned it on 30 September 2014, according to the notes of a meeting with a doctor in his community health team, did not mean that he no longer held that belief. The fact that it was common over time for beliefs to vary in the degree of conviction with which they were held, meant only that the persistent belief fluctuated. It would require a specific question to know whether a belief had gone completely.

82. In general, Dr Deeley thought that the TPIM conditions caused severe anguish to DD. DD reported severe disabling symptoms of two mental disorders, schizo-affective disorder and PTSD. He was much less able to tolerate stress than the normal person. He had made a significant suicidal gesture in an abnormal state. The TPIM contributed to the other stresses in his life, exacerbating and

maintaining the mental illness, and worsening his psychosis. He interprets the TPIM in general as a punishment from MI5, but specific TPIM conditions are particularly troublesome to him. Their impact varies from day to day, and with events, but all in the broad context of his mental illness. The effect on his children precipitated the crisis in mid-September.

83. Without the TPIM, DD's life would not be stress free, as he would still have the multi-factorial background and the effect of past violent events in his life; his mother too had been mentally ill; his eldest son was disabled. Although psychotic symptoms emerged in 2007, his trial and imprisonment, followed by the TPIM and prison again, were additional stressors. There was a clear pattern of stressors exacerbating his condition. The effects of the TPIM, such as the beliefs about the tag, and effect on the education of his children showed a relationship in time between the symptoms and the TPIM. Dr Deeley said that the reason why there appeared to have been no adverse reaction to the tag in the first six months of the TPIM could be down to DD's not reporting any, either as he saw his problems as the effect of jinns or to avoid the stigma of mental illness.

84. Dr Deeley could not say whether, without the TPIM or criminal proceedings, the illness would have receded to the point where no treatment would be necessary, but his mental health would have been better than it is. He now had a significant burden of suffering with distress, psychotic PTSD, auditory and visual hallucinations of a distressing nature, general depression, and great mental distress. The level of conviction about delusions or their prominence would vary over time.

85. The care which DD needed at the moment was in the community, but it was debateable whether the events of mid-September required admission, or daily visits at home. He needed an allocated psychiatrist, a psychiatric nurse, with regular appointments, perhaps with a psychologist. The frequency and level of care would be dictated by symptoms. If he remained on the TPIM, but received the full treatment in the community which he needed, that would provide more of a safety net in the event of a crisis; it could provide a sense of moral support, but his symptoms and the burden of the illness would remain the same, even if improved to some extent. However much the health services tried to help, the perpetuation of the conditions predisposing the mental illness would remain, so it would be unlikely or impossible to remove the mental illness. DD's mental state was at its worst now. The longer an episode of severe illness continued, the harder the prospect of full recovery. Removal of the tag would improve his symptoms, as it was particularly difficult for someone with paranoid psychosis to wear, due to its intrusiveness and its constant reminder of his perceived persecution.

Management issues

86. Ms Rose raised a number of points about the way in which the TPIM was managed by the SSHD, which she said were relevant to whether Article 3 was breached; even if those aspects could be managed better, that was not the way in which they were in fact operated. The first related to the amount of cash which DD could withdraw and hold; the SSHD had accepted that that could be increased to £200. The second concerned the frequency of reporting. The SSHD accepted, during the hearing, that the daily reporting could be reduced to four days a week.

That was not to make the TPIM compliant with Article 3, but simply because it was not necessary for daily reporting. Of course, that assumed the continued attachment of the GPS tag.

87. The third related to the computer. As I have said, the SSHD clarified before the hearing that the requirement for permission to access a website for the first time did not apply to the children or indeed to his wife. However, the computer was still not back in the house after repair, but was waiting for the cage or cabinet to be attached, which would prevent use of unauthorised devices, a fact which would make the use of the computer for the transfer of school work between home and school via a memory stick impossible. But the prime concern was the length of time the house was without a computer with the effect which that had on the children's school work, and the stress which that in turn created for DD.

88. A letter dated 15 October 2014, the second day of the hearing, from the Home Office stated that the computer would be ready for return to the house by the end of October or the beginning of November, but there was no detail in the explanation as to why the fitting of the cabinet would take so long. Ms Ross from the Home Office provided a statement dated 20 October, which set out the history in more detail. It appears that when DD went to prison most recently, the family changed the computer which had been permitted and caged, for another one. This second one had broken down and had been taken for repair. This was the one which DD wanted as his permitted computer on his release from prison on 3 July 2014. It was not until 8 September that DD told the Home Office that the computer was now repaired; he had not been chasing its repair as he was concerned that the children would access websites which they should not do, putting him at risk. That position was then clarified to him. By 13 September the necessary checks to its hard drive had been carried out by the police. By 23 September, work to disable the USB ports had been carried out. It took the Home Office until 2 October to contact the unit which makes the secure cabinet, which on 7 October confirmed that it could make the cabinet. The keyboard and mouse were collected on 10 October, and these items with the computer were sent to the unit on 14 October. Although this work is given priority, it can take three weeks to make and fit the cabinet.

89. The fourth management point related to the exclusion area, and in particular to the need to access it for medical treatment, which required specific permission from the SSHD, which could hamper treatment especially if urgent. DD was told by his probation officer and psychiatrist at the end of September 2014 that a new medical team had been identified outside that area, but DD continued to be uncertain over its identity and whereabouts. The new team may also not have included the full range of treatment to which Professor Fahy and Dr Deeley thought DD needed access. As at 15 October 2014, according to a statement from DD's solicitor, D had not yet received a letter from his new team, nor indeed did he have the community psychiatric nurse assigned to him which both doctors giving evidence thought was necessary.

The law

90. Article 3 ECHR provides that "No one shall be subjected to torture or to inhuman or degrading treatment or punishment". The imposition and continuance in force

of the TPIM as a whole was said by the Appellant to amount to inhuman or degrading treatment. There could be no lawful justification for such treatment; it was an absolute non-derogable prohibition. This was not in issue.

91. An act which is not inhuman or degrading for one person may be inhuman or degrading for another because of the particular effects which it has on one but not another: the impact of measures may be much more severe on the mentally ill than on those of a robust constitution. The reason why an act is done may affect whether or not it is viewed as inhuman or degrading treatment; that is not a question of justifying forbidden inhuman or degrading treatment, rather the reason for the act may prevent it being inhuman or degrading in the first place. Of course, that cannot apply to torture. I was taken to a number of cases which had considered these issues.

92. *Sanchez v France* (2007) 45 EHRR 49 Grand Chamber, dealt with a notorious terrorist and murderer who had been held in very restricted solitary confinement from 1994 to 2002. He had been in perfect physical and mental health throughout. The ECHR laid down the general principles in paragraphs 117-119. Ill-treatment had to attain a minimum level of severity to breach Article 3; this depended on all the circumstances, including the duration of the treatment, its physical and mental effects, and potentially, the sex, age and health of the person subjected to it. In paragraphs 118 -119, it said:

> "118. The Court has considered treatment to be "inhumane" because, inter alia, it was premeditated, was applied for hours at a stretch and caused either actual bodily injury or intense physical or mental suffering. It has deemed treatment to be "degrading" because it was such as to arouse in the victims feelings of fear, anguish and inferiority capable of humiliating and debasing them. In considering whether a punishment or treatment is "degrading" within the meaning of Art. 3, the Court will have regard to whether its object is to humiliate and debase the person concerned and whether, as far as the consequences are concerned, it adversely affected his or her personality in a manner incompatible with Art.3. However, the absence of any such purpose cannot conclusively rule out a finding of a violation of Art. 3.
>
> 119. In order for a punishment or treatment associated with it to be "inhumane" or "degrading", the suffering or humiliation involved must in any event go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment."

93. Legitimate measures which deprived an individual of his liberty might often involve an element of suffering or humiliation; but conditions [of detention in that case] had to be "compatible with respect for their human dignity", and "the manner and method of the execution of the measure" should not "subject them to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, their

health and well-being [had to be] adequately secured." The cumulative effect of the conditions had to be taken into account as well.

94. The Court considered the conditions and degree of solitary confinement, finding no breach of Article 3 before turning to its duration. In paragraph 136, the Court concluded that the length of solitary confinement called for a "rigorous examination" by the Court "to determine whether it was justified, whether the measures taken were necessary and proportionate compared to the available alternatives, what safeguards were afforded the applicant and what measures were taken by the authorities to ensure that the applicant's physical and mental condition was compatible with his continued solitary confinement."

95. *Dybeku v Albania* App 41153/06 2 June 2008, 4th section, concerned the conditions of detention of a chronic paranoid schizophrenic found guilty of murder. It restated some of the general principles from *Sanchez*. It added that, in assessing whether in any given case a restrictive regime might breach Article 3, its stringency, duration, its objective and its effects on the person concerned had to be considered; paragraph 39. Conditions had to be examined to see if they were suitable for persons suffering from mental disorder. Although ill-health did not impose a general obligation to release someone from detention, detention imposed an obligation on the state to protect the physical, and I would add, mental well-being of detainees, by providing requisite medical assistance. Paragraph 41 concluded with this:

> "In particular, the assessment of whether the particular conditions of detention are incompatible with the standards of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment."

96. Paragraph 42 noted three particular elements to be considered in judging the compatibility of detention with a prisoner's health for Article 3 purposes: his medical condition, the adequacy of medical care in detention, and the advisability of maintaining detention measure the in view of the prisoner's health.

97. *Ahmad v UK* (2013) 56 EHRR 1 concerned the conditions in which terrorist suspects would be held, if extradited to the USA and convicted, in a "supermax" prison. The availability of suitable treatment for those needing psychiatric care was relevant to whether or not detention would breach Article 3. But in general, this is a case which illustrates the principles rather than enunciating them. Of course, it does also illustrate that, had the ECtHR concluded that there was a real risk that the Article 3 prohibitions would be breached were the applicants to be detained in the "supermax" facility, they would not have been extradited unless some alternative which would not pose such a risk had been provided. *Aswat v UK* (2014) 58 EHRR 1 also concerned a terrorist suspect contesting extradition to the USA. He was a paranoid schizophrenic, with little insight into his condition. His mental illness was of sufficient severity that he had been transferred from prison in the UK to a high-security psychiatric hospital. The ECHR found that extradition would breach Article 3, because there was a real risk that he would be sent to the "supermax", and with no indication for how long, where the

environment would result in a "significant deterioration in his mental and physical health, and that such a deterioration would be capable of reaching the art.3 threshold". It illustrates what constitutes the minimum threshold of severity.

98. *H v Commissioner of Police of the Metropolis* [2013] EWCA Civ 69, [2013] 1 WLR 3021, to which Ms Rose referred, illustrates how what might be perfectly acceptable treatment for a person in sound mental health, may breach Article 3 when applied to an autistic person. In paragraph 77, the Court of Appeal attributed real significance to the fact that the legitimate objective of the police actions could have been achieved in a way which involved none or comparatively few of the steps which humiliated H. There appear to have been two strands to the Court's analysis: the treatment was in part not legitimate, as it was unnecessary to deal with the situation, and in part such treatment as was necessary was carried out in a manner which could and should have been less humiliating. The Court reached that conclusion in the light of all the circumstances. This was not an emergency in which an instant reaction was required with no time for reflection or inquiry of others.

99. This case also referred to other ECtHR cases dealing with treatment or punishment of the physically or mentally vulnerable, notably in paragraphs 70-74. *Price v UK* [2001] 34 EHRR 1285 is useful: Price, a thalidomide victim, was sentenced to seven days imprisonment for contempt of court, a sentence which the Court regarded as "particularly harsh", but not of itself breaching Article 3. The conditions of detention, in prison and police cell were such that the staff and facilities could not really cope with her needs. She could not be transferred to an outside hospital as she was not ill. That treatment did breach Article 3 because, although the sentence of imprisonment was a legitimate form of punishment, its actual effect breached Article 3 as unintended degrading treatment for her. The ECtHR did not find that no sentence of imprisonment should have been passed; it seems to assume that a prison could have been adapted to cope within a reasonably short time.

100. What the ECtHR said in *ZH v Hungary* (Application No 28973/51) unreported, 8 November 2012, about the detention on remand of someone who was deaf, dumb and with some intellectual disability, is relevant.

> "29. Moreover, where the authorities decide to detain a person with disabilities, they should demonstrate special care in guaranteeing such conditions as correspond to the person's individual needs resulting from his disability (see mutatis mutandis *Jasinskis v Latvia* (Application No 45744/08) (unreported) given 21 December 2010, para 59; *Price v United Kingdom* 34 EHRR 1285, para 30). States have an obligation to take particular measures which provide effective protection of vulnerable persons and reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge (see *Z v United Kingdom* (2001) EHRR 97). Any interference with the rights of persons belonging to particularly vulnerable groups—such as those with mental disorders- is required to be subject to strict scrutiny, and only very weighty reasons

> could justify any restrictions (see *Kiss v Hungary*, (2010) 56 EHRR I22I, para 42).)"

101. At para 32 of *ZH*, the ECtHR said that it considered:

> "in particular that the inevitable feeling of isolation and helplessness flowing from the applicant's disabilities, coupled with the presumable lack of comprehension of his own situation and of that of the prison order, must have caused the applicant to experience anguish and inferiority attaining the threshold of inhuman and degrading treatment, especially in the face of the fact that he had been severed from the only person (his mother) with whom he could effectively communicate."

102. *R v Drew* [2003] UKHL 25, [2003] 1 WLR 1213 , in paragraphs 18 and 19, shows that to deny a mentally disordered defendant facing a life sentence the medical treatment which his condition required, subjecting him to "unnecessary suffering, humiliation, distress and deterioration of his mental condition could properly be regarded as inhuman or degrading treatment or punishment." If the legislative provisions had precluded his transfer to hospital, there would have been strong grounds for challenging its compatibility with Article 3. A gap of eight days in his receipt of medication in prison, which caused a sharp deterioration in his mental health and harmed it for several months, did not give rise to effects of sufficient severity to engage Article 3.

The Submissions

103. Ms Rose submitted that the TPIM was inhuman because it involved intense mental suffering, for hours at a stretch, and degrading because of the fear and anguish of an intensity capable of humiliating and debasing DD, more than was the inevitable concomitant of the TPIM. If Article 3 were breached, there could be no justification for it, no matter what danger DD was assumed to pose without it. The TPIM either in its present form or at all, depending on where the Article 3 threshold was breached, would have to be removed, and only reimposed with conditions which kept its effects on DD below the Article 3 threshold. The tag was agreed to be the single worst factor. Although the intensity of his beliefs about the tag fluctuated, he had, it was agreed, delusional beliefs about its being a bomb and a camera. The conditions also had to be looked at cumulatively. The question was whether, with the SSHD knowing of the position, the continued imposition of the TPIM would breach Article 3.

104. It was necessary to consider how the TPIM was actually applied to him: the Home Office were obliged to do everything to reduce the stresses it caused him. If it were manageable so that the suffering did not cross the Article 3 threshold, but not in fact so managed, Article 3 would be breached. There had been no action over the reporting conditions until the hearing; there had been inaction over the computer without explanation, and it had caused stress to the children and so to DD, precipitating the crisis of 15 September. The quality of care in the community was below what was required for him.

105. Mr Hall submitted that the cases required a focus on the manner in which legitimate treatment was imposed. The threshold was not passed here. It was not at issue that DD would have required treatment for his mental health anyway, and he would experience fluctuating stress and flare ups without the TPIM. The TPIM was no bar to treatment, and DD could be treated satisfactorily. He had access to free treatment. The Court should assume that DD was receiving the treatment he needed.

Conclusions

106. The medical evidence shows a series of pictures of how DD was reacting to his circumstances. Dr Deeley and Professor Fahy agreed that DD's mental illness had begun by 2007, becoming more intense as time went by, though not featuring in medical reports until the end of 2012, and then in only a fairly minor way. The TPIM was referred to in Dr Deeley's first report of January 2014, when recounting DD's history. DD had gone to his GP when first put on the TPIM, and had received medication, but what he recounted were general feelings rather than reactions specific to any one or more conditions. At some point before he went into custody in September 2013, when the tag was removed, he was hearing voices telling him to remove it, and then expressed his preference for being in Belmarsh, since he did not have to wear the tag, which indicates a strong degree of aversion to it. By the time of the April 2014 report, when DD had been in custody for a further 3 months, DD's symptoms had eased to a degree, and Dr Deeley concluded that he was recovering from a very significant episode of mental illness, which would require treatment on release, and which could deteriorate if the TPIM were revived. Not surprisingly, by the time of the May 2014 report, when DD was back in custody having enjoyed only two days at home, Dr Deeley found him more anguished than he had been on any other occasion, suffering a significant deterioration in symptoms and an acute deterioration in mood. But three weeks later, still in custody, he was less agitated and anguished.

107. Professor Fahy interviewed him on 11 July 2014, eight days after his release, when, he accepted, DD was likely to have been in better spirits for that very reason. His conclusion was that DD's condition had improved substantially, that treatment would reduce the stressful effects of the TPIM, but that the burden of the conditions would exacerbate the residual symptoms to a modest degree.

108. However, based on an interview 6 weeks after DD had been interviewed by Professor Fahy, and so after 6 weeks living with the conditions, Dr Deeley described much more significant effects and a serious deterioration in DD's mental state. This was the longest period DD had lived under TPIM conditions since the period from its original imposition in October 2012 up to his arrest in April 2013. There then followed the events of 14-15 September 2014.

109. DD had a mental illness which would have required treatment anyway. Professor Fahy was of the view that he would need ongoing treatment even if he were not on a TPIM. Dr Deeley could not say whether the mental illness would have now receded to the point at which no treatment was necessary if there had been no TPIM, but DD's mental health would have been better than it now is, as Professor Fahy agreed.

110. Turning to his current state of mental health and the extent to which that is worsened by the TPIM, the various reports show a deterioration in symptoms over time, although there are fluctuations, in part in response to changes in circumstance which appear hopeful or distressing, notably release and return to custody. I accept that DD may have simply not reported his symptoms between October 2012 and April 2013, for fear of stigmatisation as mentally ill or because he associated them with jinns, but once he did start talking to Dr Deeley about his reactions, he did not describe them as present from the very start of the TPIM, and notably he did not so describe his delusions about the tag. I am not prepared to assume that he was at that time experiencing the same type or severity of symptoms but simply did not relate them to Dr Deeley. It follows that there has been marked change in the severity and nature of DD's reaction to the TPIM over two years.

111. Dr Deeley's last report is the first which has actually considered DD after he has been on the TPIM for more than a few days, while he is actually experiencing those conditions. In my judgment, it is to that last report that I must give greatest weight, especially as Professor Fahy did not take significant issue with the conclusions which Dr Deeley drew from it.

112. It is clear that the TPIM has exacerbated the symptoms of DD's mental illness which are PTSD, and either paranoid schizophrenia or a schizoaffective disorder, depressive type. These illnesses have caused the TPIM's conditions to have a much more significant effect on DD than they would have had on a person of normal mental health; they have maintained and exacerbated his illnesses, so that his mental health is worse than it would have been without the TPIM - whether or not without it, his health would have improved to the extent that treatment was not necessary. Although DD's delusions and symptoms fluctuate, and his beliefs may be held with varying intensity and conviction over time, I accept Dr Deeley's evidence that the TPIM conditions cause severe anguish, though fluctuating, and that he has a significant burden of suffering. I also accept that the longer the TPIM remains in force, the worse the prognosis and the more difficult the eventual recovery after its removal. Professor Fahy said that DD would be prone to crises, from the TPIM and family problems, which is consistent with Dr Deeley's analysis.

113. Dr Deeley and Professor Fahy were also agreed that DD required treatment in the community, with risk assessment, medication regularly monitored, an allocated psychiatric consultant, the support of a community psychiatric nurse, regular appointments, and a psychologist if necessary. This is much what he would need at present if the TPIM were removed, although his symptoms are worse with the TPIM.

114. I accept that the fact of the TPIM, about which DD maintains the delusion that it is a punishment by the Security Service, and which risks a cycle of breach, custody, release, revival and breach again, leads to an understandable sense of hopelessness. I accept that four of the restrictions are identified as more significant than the others in their specific effects, with the tag being the most troubling to DD's mental state by a considerable margin. All of these effects are significantly more serious for DD than they would be for a person of normal mental health and insight.

115. The fundamental issue raised on the submissions concerns the relevance of the TPIM itself. If the TPIM had no legitimate purpose, was unnecessary for the achievement of that purpose, or was wholly out of proportion to the risk it was designed to meet, or was imposed with the intention of humiliating DD or to cause him suffering, and had these effects, it would plainly breach Article 3. But although it was deliberately imposed or revived, there was no intention to humiliate or debase, nor was it a premeditated act intended to cause suffering. That is not conclusive on Article 3, but the fact that it is relevant at all does point strongly to the relevance of the reason why the acts were done, and not just to their effects. Absolute though Article 3 is, and a breach of it is incapable of justification, that does not necessarily resolve the significance of the reasons for the TPIM, and its conditions. Do they merely seek to justify impermissibly a breach of Article 3, or can they go to the question of whether Article 3 had been breached in the first place, or to the level of suffering which would amount to breach of Article 3, or to the provision of necessary medical care?

116. In principle, the authorities seem to me to show that acts may or may not breach Article 3, depending significantly on the nature or legitimacy of the acts themselves, the intent with which they were done, the reason for them, their necessity, proportionality to that need, the availability of alternatives and consequential treatment, and not just on the degree of effect on the particular individual. Imprisonment is a legitimate form of treatment for those convicted of crimes, and transfer to a mental hospital is a legitimate form of treatment for mentally ill offenders.

117. Imprisoning someone, however, simply to humiliate him, or with no legitimate reason, may breach Article 3, even though the conditions experienced and the effect on the individual may be the same as if done following the sentence of a court. Handcuffing someone in public, for example, may or may not breach Article 3 depending on that person and the reason for putting him in handcuffs. A person whose mental or physical condition means that detention in prison would breach Article 3, does not have to be released, rather than transferred to hospital. The mentally ill patient who reacts adversely to confinement in a secure hospital is not released to be a danger to himself and the public, but is treated as best as may be in hospital. The severity of the impact does not require their release, regardless of the danger they pose to themselves or to others. A person detained in a secure hospital because of the dangers he poses would not be released if he believed that the staff intended to kill him at any moment, nor if he believed that they were part of a conspiracy with , say, the police, to harm his family while he was detained. If detention in hospital is necessary to protect the public, yet itself causes a severe deterioration in mental health, I see nothing in domestic or ECtHR jurisprudence which, for that reason alone, requires release. The state may have to improve facilities and provide care of a particular sort to avoid a breach of Article 3.

118. The judgment as to whether Article 3 has been breached is reached not just against the impact on the individual, but against the necessity and proportionality to that need of the underlying "treatment", and the possible alternatives, in the manner of its execution. All that is clear from *Sanchez,* and paragraph 136 in particular. The "practical demands" of punishment were very relevant.

119. *Dybeku* develops *Sanchez* in the context of a mentally ill murderer. Again, the emphasis is on examining and adjusting conditions for such a person, and providing requisite medical care. It does not make the patient's health or welfare the determinant, regardless of the risk he poses.

120. The principles in *Sanchez* and Aswat are not in conflict. There was a real risk in *Aswat* that Article 3 would be breached. The public interest in extradition does not justify breaching Article 3. That is well-established and applied routinely. Once a breach, or in "foreign" cases a real risk of a breach, has been established, it cannot be justified or balanced against other public interests. But in establishing whether or not a breach of Article 3 has occurred through inhuman or degrading treatment, the nature, or legitimacy of the "treatment", the necessity and reason for it, its proportionality, its effect, the intent of the state actor, the availability of alternatives, and the medical or other treatment in response all come into the judgment. In extradition cases, the real risk of a breach of Article 3 leads to the refusal of surrender, because the contested treatment is not legitimate or necessary; if extradition takes place either by the requesting state providing appropriate assurances for action in an individual case or by improving its more general treatment of prisoners in at least one location to which the extradited person might go, the treatment is legitimate, and there would be no breach of Article 3.

121. *Price* might have addressed the issue, but in reality the ECtHR did not grapple with the real cause of the problem which was the immediate sentence of imprisonment without knowing what arrangements if any could be made for the contemnor. There was no evidence that better alternatives existed but were not sought or were ignored; nor did the ECtHR, seemingly accepting with reluctance the legitimacy of the immediate sentence, say what else should have been done. It seems to have assumed that detention facilities could have been found or found with time, and that that ought to have been resolved before the sentence took effect.

122. *ZH* points out that special care is needed in dealing with the vulnerable, taking effective steps to protect them, with very weighty reasons required to justify any restrictions. It was the remand into custody which was the breach of Article 3, where incarceration was ordered without the requisite suitable arrangements being made in a reasonable time. Some measures were taken after 6 weeks of the 3 month remand, but they were insufficient to prevent a breach of Article 3. The requisite measures were not specified, but the Court did not decide that there should have been no remand in custody for the offence of robbery. It simply decided that the relevant but unspecified measures should have been taken when he was remanded, quite demanding though it appears they would have had to be. It has to be assumed that it had in mind measures which were or could have been made available within reason. The Court did not hold that a custodial remand was neither the necessary or proportionate response for him in principle. *R v Drew* is much in the same vein.

123. Accordingly, a judgment on legitimacy, necessity, and proportionality in relation to that necessity, in all the circumstances is required. The judgment cannot simply look at the effect which a measure has on the individual, and then conclude that, though for example detention is necessary, proportionate to the need, and the

detainee is in receipt of proper treatment, the effect crosses some threshold of suffering such that he must be released.

124. The parties agreed, for the purposes of this preliminary issue only, that the Respondent's national security case was accurate. The TPIM is in principle a legitimate form of treatment for someone who presents the necessary degree of risk. It was also agreed that the Court could assume that the TPIM itself and all of its conditions were necessary to counter the risk which DD had to be taken to pose for national security. It follows that I have to assume that DD retains the capacity and intent to engage in those activities which make the TPIM necessary, his mental health problems notwithstanding. It must also follow that the TPIM, with its conditions, has to be taken to be for these purposes as a legitimate form of treatment to meet the risk to the public which DD poses in this mental state. The question of whether there might be alternative or lesser measures which would be adequate to counter the risk, or which should be accepted in view of the effect of the present conditions on DD's mental health, cannot be answered at this stage; it would have to await the substantive appeal. I have to assume that the conditions, are indeed proportionate to the risk. This poses real difficulties in dealing with the preliminary issue. This Court is in the rather artificial position of not being able to judge, as it would be able to at the substantive hearing, whether the risks established warranted all of the restrictions, and even if they did, what the degree of risk would be if a less satisfactory way of meeting them were required, balancing the impact on DD with the impact on the risk he poses. The problem which this preliminary issue creates is how far those necessary assumptions, subject to the availability of medical treatment, really answer to the preliminary question. It is impossible to reach a view about Article 3, in cases of this sort, in a circumstantial vacuum, as the authorities show: all the circumstances must be considered. This preliminary issue requires the vacuum to be filled by assumptions unfavourable to DD.

125. I cannot accept the essential premise of Ms Rose's submissions that, in an Article 3 case based on alleged inhuman and degrading treatment, the question is simply whether the degree of suffering has reached a level of intensity which requires the actions to cease, regardless of their purpose, legitimacy, intent, alternatives, and care provided. The authorities simply do not warrant that approach. And it runs counter to all sense to ignore the reasons behind what is a legitimate and necessary form of treatment for an admitted risk.

126. In the circumstances as I must assume them to be, I have to conclude that the TPIM restrictions, including the effect of the tag, do not amount to a violation of Article 3, provided that the requisite measures for the care of DD, including those measures which arise from the imposition of the TPIM, are met. Those requisite measures cannot include quashing the TPIM since the TPIM is, by necessary assumption, a legitimate measure necessary and proportionate to the risk. Nor can they include quashing the TPIM with a view to its re-imposition, minus the tag requirement, for the same reason; that measure is legitimate, necessary and proportionate to the risk.

127. Accordingly, although the TPIM has severe effects, it does not fall to be quashed on that ground on this preliminary issue. That, however, leaves the question of the manner in which it is executed. The management of the conditions by the SSHD is

therefore relevant to the question of whether or not there is a breach of Article 3. First, if the SSHD is not taking the steps necessary to provide the treatment for DD which he requires on the TPIM, there would be a breach of Article 3, to be remedied by taking those steps. This is the equivalent of the state having to transfer to hospital those who cannot be treated in prison where the latter would involve a breach of Article 3.

128. DD's exclusion from an area popular with the Somali community removes a source of support but is not of real significance in itself. But there has been a problem which ought by now to have been resolved, in that DD's exclusion from this area meant that treatment from his community health team within it could only be obtained after the Home Office had permitted entry to the area, with the delay which that could entail- unless the health team were always able to make a home visit as a priority. That has been resolved by the provision of a health team outside that area but the provision only exists in reality once the team has been identified to DD, which appeared not yet to have happened at the time of the hearing but which ought to have been resolved by now.

129. The new health team will have to consider what Dr Deeley and Professor Fahy have said about DD's treatment. There should be an allocated consultant psychiatrist, but it will be for that psychiatrist to decide what treatment is required. So long as DD is on the TPIM, that will be what the SSHD will have to provide, to avoid a breach of Article 3.

130. It was his family's choice to change computer; computers break down anyway. The real delay has come in fitting the secure cabinet to a different computer. The impact on his children's school work, and hence on him, of that delay is significantly more serious than for others as the crisis of mid-September showed. But, putting to one side any other steps which his children might be able to take, such as access to a computer at school, this particular problem will shortly be resolved, if it has not already been resolved. The crisis was dealt with. The fact that such crises may occur does not necessarily show a breach of Article 3 through the way the conditions are managed. Even if, and I am not in a position so to conclude, there was avoidable delay in dealing with the work to the computer or more likely in the cabinet fitting, with a temporary worsening of his mental state, I do not regard that as breaching Article 3.

131. The ability of the children to access a website without requiring permission has been made clear. So DD should be able to appreciate that misadventure on their part is not a risk to him. Their schoolwork, in terms of accessing the internet and working on the computer will be unaffected; he is capable of understanding that. The inconvenience, for which he is likely to feel responsible, because they cannot use a memory stick rather than email to transfer documents from school to home, does not require alteration to avoid a breach of Article 3 in the manner of execution of the legitimate TPIM.

132. While DD finds reporting extremely aversive, there has been a modest reduction in the frequency of reporting required. There is a difference of degree in the medical evidence about the difference which removal of this condition would make. But even in Dr Deeley's view, it is clear that DD has coped. I cannot see anything in its effect on him which begins to approach the threshold of a breach of

Article 3. The cash restriction has been significantly alleviated as DD can appreciate. The accumulation of these management issues does not breach Article 3 either. although the SSHD will need to be very aware that the manner in which the TPIM is executed requires speedier responses than would be the case with a person in good health, and an approach more conscious of and sensitive to the difficulties under which DD labours in compliance with the restrictions.

133. If I am wrong in my analysis above, and there is a point at which the level of suffering is so great that, no matter the risks which the cessation of the necessary and legitimate treatment would create and no matter the quality of the care provided, the action in question must stop, this case was not close to what would inevitably be a very high threshold when the TPIM was revived in July 2014, and in my judgment is still below it.

134. The absence of premeditation, that is a deliberate act of inhumanity and of intent to humiliate or degrade is very significant through not conclusive. The imposition of a TPIM with such restrictions is a legitimate and proportionate measure to deal with the risk which DD poses to the public of engaging or re-engaging in terrorist-related activities, even if, notwithstanding requisite medical care, of itself that is not conclusive, either.

135. When the TPIM was revived on 3 July 2014, the report of Professor Fahy, and indeed, the earlier experience of DD under the restrictions of the TPIM, shows that it did not then amount to a breach of Article 3. He thought that DD's distress had been significant but mild, and DD appeared to be coping. This was notwithstanding the significant impact which the TPIM had had on DD's mental health, increasing stress levels and with some conditions being especially problematic.

136. Currently, the effects of the TPIM in general, whatever the particular effects of certain restrictions, and the effects of the three most contentious conditions apart from the tag, plainly do not cross that high threshold so as to breach of Article 3. I reach that conclusion recognising that the maintenance of the TPIM and those conditions is significantly worse for DD than for a person who is in normal mental health, and that particular care is required in judging whether a mentally ill and vulnerable person is being treated with proper respect for the fact that he is a human being.

137. The tag as described by Professor Fahy and Dr Deeley is undoubtedly the most severe requirement in its impact on DD, because of his paranoid ideation. DD's delusions about the tag being an explosive device and a camera are very frightening and distressing. He wants to remove it, as voices tell him to, yet knows this would continue with the cycle of breaching the TPIM, facing prison, release, revival of the TPIM and breach. The doctors agree that the removal of the tag would not simply lead to paranoid delusions associated with it being transferred to another object, because of the particular nature of the tag. Its removal would reduce the number and intensity of the stressors he has to cope with, which could increase his ability to handle those which remain. That is a judgment I make, but it is consistent with the medical evidence; indeed it seems obvious. However, I am not persuaded that the effect of the tag, on top of the other TPIM effects, does

breach Article 3 in these circumstances in view of the high threshold required to be crossed.

138. I note that the parties agreed that were I to conclude that the wearing of the tag or other conditions pushed the current effect of the TPIM above the threshold for a breach of Article 3, I could not simply require the TPIM to be varied by the removal of that requirement. I would have to quash the TPIM as a whole, leaving the SSHD to impose what TPIM she then thought appropriate in the light of the judgment, perhaps with other restrictions such as returning to a seven day a week reporting requirement. But that does not arise in the light of the conclusions to which I have come.

139. Accordingly this application is dismissed.